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In this issue:

35 Hospital Development and Communities

38 The Unappreciated Incentive

40 Hospital Costs
Analysis of Hospitals Over 500 Beds

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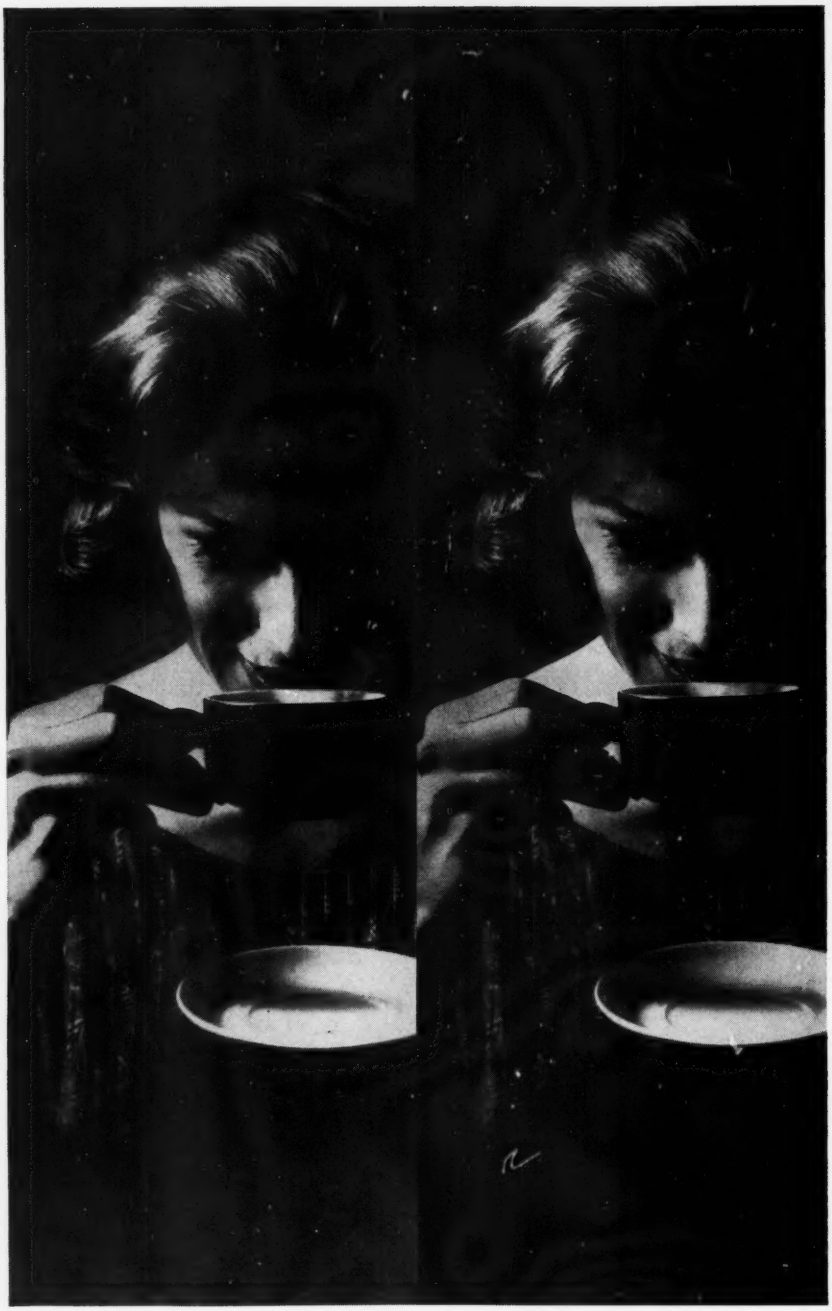

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July 1961 • VOLUME 92, Number 1

FEATURES

6 Introducing Methods Improvement: *Allen M. Hicks*
Employees look at work differently after they have been involved in a methods improvement program.

35 Hospital Development and Communities: *Beatrice Dinerman*
To what extent are hospitals established in response to a need? And what determines the need?

38 The Unappreciated Incentive: *Albert V. Whitehall*
Are we in danger of loosing our most powerful force toward quality hospital care—the paying customer?

40 Hospital Costs—Analysis of Hospitals over 500 Beds: *Charles U. Letourneau, M.D., Melinda Ulveling, Patricia Heuser*
What is the influence on costs of outpatient visits, residency programs, internships and accredited schools of nursing?

46 Housekeeping Records: *Rosalie E. Cain*
Of value are records on linen issues and discards, sewing room requisitions, budget requests, keys, sewing reports and a daily diary.

48 Engineering Management: *Daniel M. Roop*
What is your cost per patient day for plant operations? What percentage of total general costs of overhead is represented by utilities?

57 Purchasing Under Budget Law: *R. M. Drowne*
Even under an inflexible budget amount, the P.A. must forecast, purchase, record and know the needs.

64 Defrosting Times of Frozen Turkeys: *Lenora Moragne and Karla Longree, Ph.D.*
How long does it take a turkey to defrost? Is one method faster than another?

72 More About Anti-Depressant Drugs: *Inese Z. Ziedins*
A description of some of the anti-depressant drugs.

DEPARTMENTS

ACHA News and Views 45
Bluestone Column 76
Classified Advertising 75
Consulting with Doctor Letourneau 21
Engineering-Maintenance 48
Food and Dietetics 64
Hospital Accounting with Professor Martin 18
Housekeeping 46
How's Business 8, 10
Index to Advertisers 77
Law 24
Medical Records 28
Menus 68
NAHPA Newsletter 57
NAHCSP Newsletter 53
Pharmacy 72
Reprints Available 40
Small Hospital Clinic 6
Washington Bureau 14

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small hospital's clinic

Introducing Methods Improvement

by Allen M. Hicks
Pekin Public Hospital
Pekin, Illinois

■ Pekin Public Hospital requested $1,200 from the Forest Park Foundation for the purpose of starting a Methods Improvement Program with Frank Mergen, head of the Industrial Engineering Department at Bradley University, serving as the guidance to our program. All of the grant went to Bradley University for the service of Professor Mergen and his associates.

We started the program in July, 1959, by having a film and brief orientation program for all hospital employees. Then we held a series of five one-hour sessions for all employees interested in learning more about methods improvement. Twenty-five employees completed all five of these lectures and 67 other employees attended some of the sessions. During this orientation period, several members of the medical staff requested a one-hour orientation session which proved to be helpful.

After orientation, the method of approach to the Pekin Public Hospital (185 beds) program was to be the committee approach. The committee would be made up of employees from the area being studied. With the administrator as chairman the committee included the dietitian, director and assistant director of nursing, administrator's secretary, comptroller and the home care director. Three of the seven committee members have had short courses in methods improvement.

The first few months' accomplishments have been of three types.

1. *The direct project accomplishment.* In the first few months, about 20 projects have been worked on of various magnitudes. In nursing, we have solved four 11-7 nursing staff projects which eliminated one house supervisor's report (which was never used) that took one hour a night for the last four years. This eliminated drawing midnight lines on all nursing notes, which substituted a 115-minute IBM patient listing to substitute for the nurse's writing a condition report and diet report for each patient nightly. On the day shift in nursing, we arrived at a new linen distribution system that cut down on linen use and distribution time for laundry and nursing personnel. We saved one mile of unnecessary walking a week for a dietary aide who prepared afternoon nourishments. We saved unnecessary weekly walking and work for one ice distribution janitor. There are about 20 such projects completed to date. Many of the solutions to these projects were simple and obvious, but prior to methods improvement in our hospital no one bothered to think about them.

2. *Sampling.* To date, we have sampled four nursing stations on all three shifts to find out how our nursing personnel spend their time. The purpose of this study is to try to make better use of our nursing personnel. This sample told us some of the following things:

a) From 8 to 11 percent of the time of one head nurse is spent in answering the telephone on the 7-3 shift.

b) Of the nurse's time 28 to 39 percent is spent in preparing, administering and transporting the medicines.

c) Charting accounts for 17 to 30 percent of the head nurse's time on 7-3 and 8 to 28 percent of other on-duty nurse's time.

d) On 3-11, about 17 percent of the time of our nurses aide was spent in delay or waiting.

Our hospital has never had ward clerks and the advent of ward clerks was obvious before we started; however, from the sample, we now know exactly what the ward clerk's job shall be, how many shifts she is needed, and how effective she has been after employment because we will again work sample the unit for her effectiveness.

When it was found that about 28 percent of our nurse's time was spent in preparing and administering drugs, we decided to study this procedure in detail under the projects as mentioned in type one.

3. *Employee awareness.* Because of the methods program, employees, as they become a part of the program, automatically start looking at the work that they are doing differently and some direct benefits result. ■

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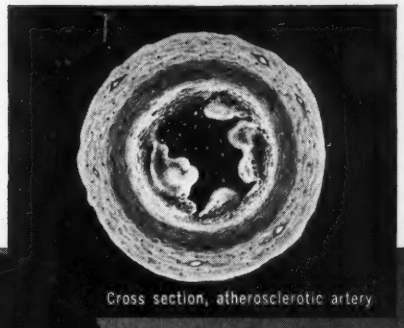

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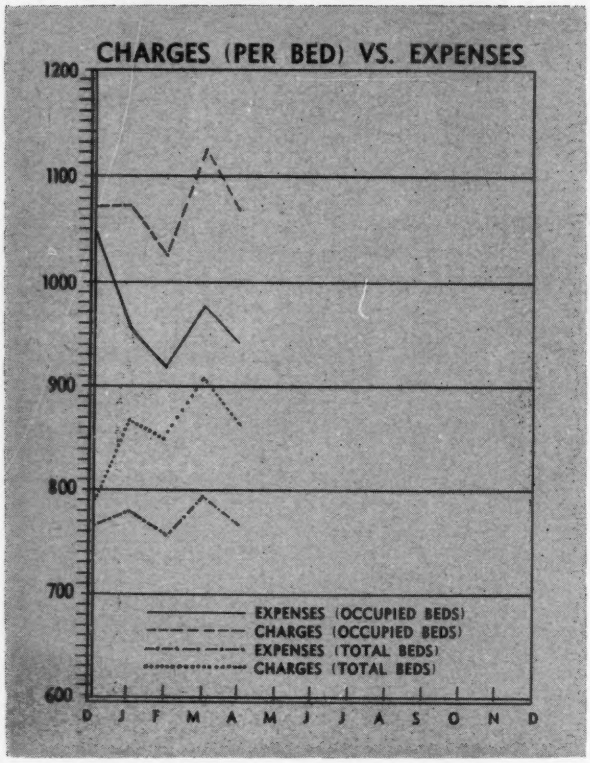


how's business?

(See also page 10)

■ GENERAL FUNDS SURPLUS is an account that does not seem to get much use in the accounting practices of our hospitals.

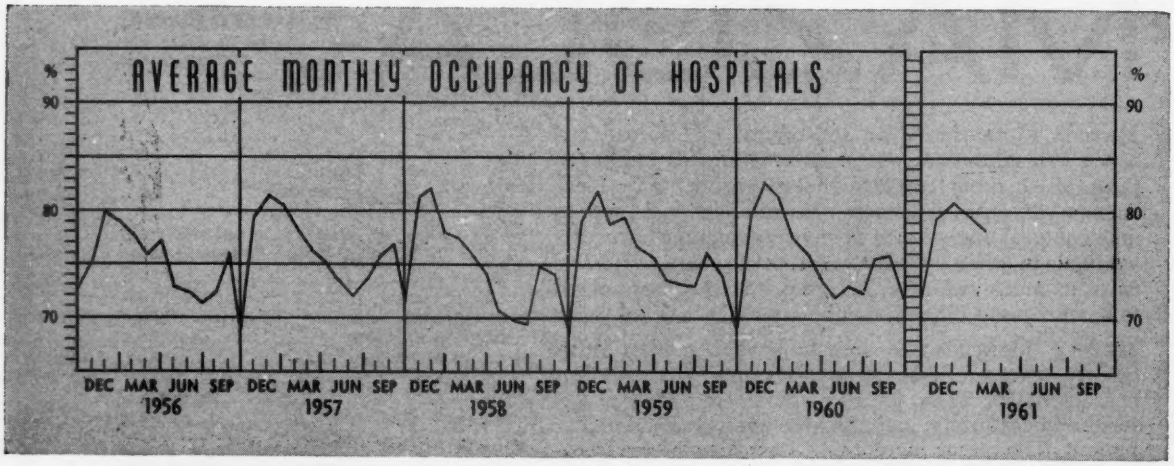
Last month our sample reported that only 13 percent have charged to this account during the past three years. The remaining hospitals reported negatively. ■

Average Operating Expenses Per Occupied Bed Per Month	
March, 1960	958.97
April, 1960	965.96
May, 1960	1026.69
June, 1960	977.48
July, 1960	1034.11
August, 1960	1025.95
September, 1960	1001.85
October, 1960	1001.05
November, 1960	993.48
December, 1960	1043.75
January, 1961	954.73
February, 1961	912.71
March, 1961	976.67
April, 1961	941.85

Average Patient Charges Per Occupied Bed Per Month	
March, 1960	1093.36
April, 1960	1081.27
May, 1960	1137.90
June, 1960	1075.49
July, 1960	1099.81
August, 1960	1114.64
September, 1960	1071.61
October, 1960	1097.03
November, 1960	1095.98
December, 1960	1071.11
January, 1961	1071.29
February, 1961	1023.76
March, 1961	1123.27
April, 1961	1069.81

Average Operating Expenses Per Bed Per Month (Total Beds)	
March, 1960	789.87
April, 1960	768.31
May, 1960	800.81
June, 1960	753.68
July, 1960	760.35
August, 1960	763.53
September, 1960	745.63
October, 1960	771.08
November, 1960	776.40
December, 1960	765.51
January, 1961	778.00
February, 1961	755.78
March, 1961	794.65
April, 1961	767.77

Average Patient Charge Per Bed Per Month (Total Beds)	
March, 1960	895.38
April, 1960	855.00
May, 1960	886.94
June, 1960	824.03
July, 1960	800.13
August, 1960	826.68
September, 1960	792.80
October, 1960	844.26
November, 1960	849.61
December, 1960	787.78
January, 1961	867.72
February, 1961	845.91
March, 1961	907.11
April, 1961	862.69



Average Monthly Occupancy (on 100 percent basis)	
January, 1960	79.79
February, 1960	82.98
March, 1960	80.12
April, 1960	77.46
May, 1960	75.69
June, 1960	73.70
July, 1960	71.87
August, 1960	72.65
September, 1960	72.18
October, 1960	75.52
November, 1960	75.54
December, 1960	71.46
January, 1961	79.58
February, 1961	80.89
March, 1961	79.47
April, 1961	78.18

Average Length of Patient Stay (in days)	
September, 1960	6.8
October, 1960	6.9
November, 1960	7.0
December, 1960	7.0
January, 1961	7.1
February, 1961	7.3
March, 1961	7.0
April, 1961	6.9

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April 1961 Regional How's Business Report

REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,617	4,059	11,743	1,530	4,171	10,225	1,700	3,555	7,641	1,334	3,697	7,072
% of OCCUPANCY	77.65	83.87	90.47	78.70	81.64	87.39	73.37	77..70	83.79	72.50	77.25	78.38
EXPENSES BY DEPTS. Per Patient Day												
Administration	4.09	4.72	4.34	3.23	3.11	3.45	3.01	3.27	3.09	3.85	3.41	5.69
Dietary	3.69	4.12	4.46	3.20	3.45	3.57	3.12	3.48	2.91	3.07	3.41	3.34
Housekeeping	1.50	1.82	1.60	1.18	1.31	1.48	1.12	1.14	1.08	1.13	1.22	1.17
Laundry	.97	.76	.69	.62	.60	.66	.63	.66	.43	.67	.68	.81
Plant Operation	2.47	2.17	2.67	2.09	2.04	2.16	1.57	1.97	1.46	2.08	1.90	2.21
Medical & Surgical	.93	1.64	1.58	1.38	1.17	1.86	1.99	1.67	1.50	2.49	1.34	2.41
O. R. & Del. Rms.	1.94	2.21	2.09	1.23	1.50	1.42	1.69	1.93	1.93	1.64	2.69	2.96
Pharmacy	1.41	1.50	1.31	1.50	1.25	1.29	1.44	1.34	1.43	1.87	2.11	2.34
Nursing	8.68	8.37	7.16	7.44	6.91	6.66	6.61	6.77	5.75	6.31	7.34	9.40
Anesthesia	.60	.44	1.56	.62	.52	.82	.60	.59	.44	.72	.65	.91
Laboratory	2.12	2.76	2.62	1.58	1.94	2.24	1.58	1.89	2.08	2.16	2.65	2.86
X-ray	1.91	2.00	2.04	1.57	1.62	1.32	1.81	1.56	1.58	1.31	1.99	1.86
Other expenses	.33	.94	2.12	.62	.85	1.26	1.12	.67	1.01	.76	1.04	1.43
TOTAL EXPENSES	49,351	139,041	408,971	39,298	111,773	299,778	43,139	98,678	193,827	36,018	113,428	258,282
TOTAL CHARGES TO PATIENTS	58,527	159,803	459,036	44,963	137,032	347,036	45,673	115,832	226,708	40,364	129,236	281,133
OPERATING INCOME PER PATIENT DAY	36.19	39.37	39.09	29.39	32.85	33.94	26.87	32.58	29.67	30.26	34.96	39.75
OPERATING EXPENSES PER PATIENT DAY	30.52	34.26	34.83	25.68	26.80	29.32	25.38	27.76	25.37	27.00	30.68	36.52

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan, Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,389	3,819	9,015	1,046	3,433	8,881	1,152	3,630	6,405	1,284	3,582	6,431
% of OCCUPANCY	71.95	79.66	86.97	66.20	75.56	84.56	69.13	77.38	79.29	66.64	75.46	80.84
EXPENSES BY DEPTS. Per Patient Day												
Administration	3.77	4.03	4.42	2.44	3.08	3.63	4.55	3.92	4.50	5.29	5.55	5.48
Dietary	3.48	3.45	3.61	2.84	3.48	3.94	3.39	3.66	4.27	4.12	4.10	4.64
Housekeeping	1.35	1.58	1.62	1.08	1.24	1.68	1.40	1.73	1.36	1.75	2.05	1.86
Laundry	.72	.69	.71	.68	.64	.66	.98	.85	.88	1.26	1.08	1.13
Plant Operation	1.95	2.16	2.04	1.45	1.79	2.35	2.54	2.27	1.89	3.07	1.92	2.22
Medical & Surgical	1.48	1.77	2.16	1.46	1.77	2.40	1.54	1.48	1.39	3.06	1.63	2.50
O. R. & Del. Rms.	1.93	2.06	1.75	1.34	1.90	2.45	2.26	2.12	1.94	4.67	3.76	3.58
Pharmacy	1.54	1.49	1.47	1.49	1.38	1.58	2.93	1.98	1.45	1.72	1.96	1.97
Nursing	8.28	8.47	8.60	7.05	7.11	6.42	9.19	10.59	8.88	11.82	11.50	13.41
Anesthesia	.81	.54	.44	.38	.35	.52	1.00	.46	.29	.50	.68	.54
Laboratory	1.99	2.47	2.28	1.38	1.69	2.68	2.22	2.73	2.66	3.11	2.74	3.51
X-ray	2.05	2.08	1.86	1.30	1.66	1.77	2.10	1.91	2.20	2.46	1.88	2.60
Other expenses	.83	.68	1.03	.60	.69	1.76	.51	.88	.78	2.73	1.17	.84
TOTAL EXPENSES	40,017	119,761	289,177	23,188	93,228	285,030	38,096	124,887	206,574	53,988	140,582	286,440
TOTAL CHARGES TO PATIENTS	44,243	131,210	334,999	25,088	102,914	321,823	44,498	124,197	219,496	58,056	156,759	315,986
OPERATING INCOME PER PATIENT DAY	31.85	34.36	37.16	23.98	29.98	36.24	38.63	34.21	34.27	45.22	43.76	49.13
OPERATING EXPENSES PER PATIENT DAY	28.81	31.36	32.08	22.17	27.16	32.09	33.07	34.40	32.25	42.05	39.25	44.54

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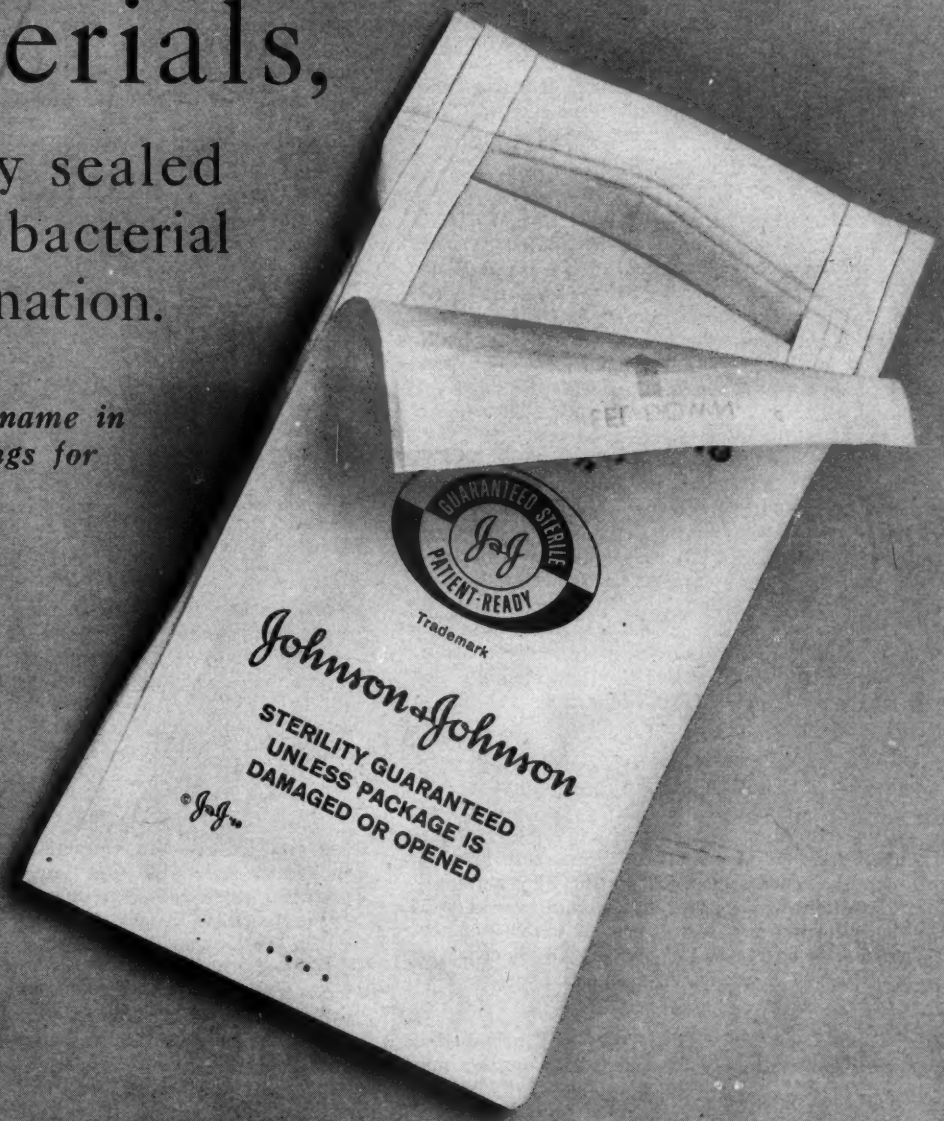

James D. Snyder

Washington Bureau Reports

■ On June 1, James D. Snyder became Washington Bureau Chief and Eastern Editor of the Clissold Publishing Company businesspapers succeeding Walter N. Clissold, who as Executive Vice President of Clissold Publishing Company and Publisher of Hospital Management and The Hotel Monthly, two Clissold publications, will be headquartered in Chicago after June 1.

James D. Snyder joined Clissold Publishing Company in July, 1960, as a staff member of the Washington Bureau. The son of Harold E. Snyder, Vice President of Clissold Publishing Company and Editor and Publisher of Baking Industry, he is a 1958 graduate of Northwestern University's Medill School of Journalism, where he majored in political science in Northwestern's School of Liberal Arts as well. He is a member of Sigma Delta Chi, honorary journalism fraternity and of Beta Theta Pi. He, his wife Sue, and daughter Cheryl Sue, live in Arlington, Va.

HEARINGS ON THE ADMINISTRATION'S "ELDERCARE" BILL have finally been scheduled "shortly after July 4" by the reluctant House Ways and Means Committee Chairman Wilbur Mills (D., Ark.). Although it is questionable whether both Houses will have time to act before the summer recess, the handwriting on the Congressional wall would indicate that hospital and nursing home insurance for the aged will be brought under the social security system. The liberal Senate seems perfectly amiable. And while a stiff fight is expected in the House, the GOP-Southern Democratic opposition is roughly the same combination that was clearly defeated in the recent minimum wage vote. The American Medical Association may try to extend committee hearings until adjournment time in hopes of picking up more support during the fall. But the odds seem to be that they won't buck the tide built up by Presidential patronage, the AFL-CIO, and the persistent Wilbur Cohen. As a matter of fact, the Social Security Administration has already requested $320,000 from Congress to build additional facilities.

ADDITIONAL SOCIAL SECURITY BENEFITS were approved by the House and awaited almost certain Senate passage at this writing. Employers would pay a ⅛ of 1% increase in the present 3% payroll tax to finance the following benefits: 1) an increase in minimum monthly benefits from $33 to $40; 2) relaxed eligibility laws that would cover 160,000 more workers; 3) an option allowing men to retire at 62 on 80% of normal benefits; 4) increases in payments to widows from 75% to 82½% of a worker's retirement benefits.

THE "NEW LOOK" IN CIVIL DEFENSE proposed in President Kennedy's May 25 speech to Congress may spell an increased role for hospitals in peacetime mobilization. JFK spoke of "new requirements to include fallout shelters in buildings constructed with federal assistance." However, he left unclear such questions as: would shelter construction in federally-assisted Hill-Burton hospitals be made mandatory? If so, would this be paid from civil defense funds or by private participants? Although he left other areas hazy as well, the President *did* advocate: 1) "tripling" the current civil defense appropriation; 2) increasing medical stockpiles; 3) transferring functions of the present Office of Civil Defense Mobilization to other federal agencies. What's left of OCDM would coordinate government activities and advise the President under the title of Office of Emergency Planning.

THE RECORD $641 MILLION NATIONAL INSTITUTES OF HEALTH BUDGET voted by the House contains $10 million for construction of two hospital research facilities. The request came after a medical team from Mayo Clinic and Rochester (Minn.) Methodist Hospital impressed the Appropriations Committee with the "serious lack of hospital research in what is regarded as the nation's third largest industry." The doctors testified that experiments with circular intensive care units saved the nurses steps and cut patient charges by $38 a day compared to charges in rectangular-type units. They urged that similar experiments with circular rooms be made to test the cost and quality of treatment furnished to patients in other stages of Progressive Patient Care. If the Senate approves the measure, two working research hospitals would be built in separate communities with two-thirds federal aid. Hill-Burton would presumably supply the research staff.

HOSPITAL CONSTRUCTION has been included in the president's repertoire of anti-recession weapons. Following a White House directive, Hill-Burton has ordered its state agencies to accelerate applications processing as close as possible to the fiscal year beginning July 1. By holding advisory council meetings earlier, approving state plans faster, community hospital construction projects can be notified to begin sooner—thus stimulating employment and purchases in the hard-hit building materials industry. This is good news for many individual applicants who now stand to get the green light months ahead of schedule.

READERS HAVE ASKED why the Justice Department has not contested the so-called "price schedules" recently mailed by the American Medical Association to members. The suggested guides are based upon units rather than price (one unit for a house call, 10 for a minor operation). Some eyebrows were raised because another professional group, the Northern California Pharmaceutical Association, is now in court fighting a price fixing charge for circulating lists suggesting fixed percentage mark-ups on drugs. Although Justice Dept. has not looked into the AMA case fully, one top spokesman told HM that the Clayton Antitrust Act prohibits price collusion only in the sale of tangible goods (such as drugs). Doctors, instead, sell services, which aren't regulated. The California pharmacists vehemently protest that they do indeed perform a service requiring many years of professional training. However, Justice still contends that pharmacists are primarily go-betweens in the dispensing tangible merchandise. ■

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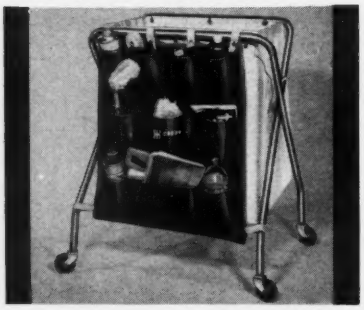

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Inquiry:

Do you think a statement of sources and application of funds is a useful statement for purposes of hospital administration?

Comment:

A statement of sources and application or disposition of funds for an accounting period should be just as useful in the administration of a hospital as for an industrial or commercial enterprise. Such a statement provides the administrator or trustees of the hospital with an overall condensed picture of where funds came from and for what major purposes they were expended. It is an excellent form of statement to compare periodically with the budgeted cash flow statement or projected statement of cash receipts and expenditures. The advantage of the funds statement over the ordinary statement of cash receipts and disbursements is that it considers receivables and payables as well as prepaid expenses and income received in advance and thus more nearly presents the fundamental working capital position.

Inquiry:

If a donor has donated ownership of a life insurance policy to a hospital and continues to pay annual premiums on the policy, what investment value, if any, should the hospital record in its accounts? Does the hospital derive income annually if the policy increases in value?

Comment:

If legal ownership is vested in the hospital, the hospital would derive income from the original gift equal to the cash surrender value of the policy. It would probably be classified as a temporary fund since it is not immediately available for expenditure, but is not permanent in nature. Annual payments of premium do not represent income to the hospital, but the increase in cash value arising from the payment of the annual premiums does represent income to the hospital. The income presumably would be recorded by a debit to an asset account, such as, Cash Value of Insurance Policies Owned and by a credit to Income From Contributions. The cash value of such policies would be carried as an investments account on the balance sheet. The income would appear as other revenue on the statement of income and expense.

It should be observed that the donor's payment of annual premiums represents annual gifts since the proprietary interest in the policy is vested in the hospital. However, the value received by the hospital is only the increase in cash value. At the donor's death the hospital will realize income in the amount of the difference, if any, between the cash value shown in the records and the face of the policy. ■

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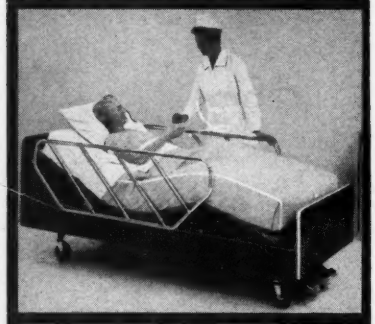

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Medical Record Committee

QUESTION: *We have about 800 discharges per month and it is utterly impossible for our three man medical record committee to review each of the charts of the discharge patients. How do they do it elsewhere?*

ANSWER: No physician should be asked to examine more than 100 charts per month. This is an average of 3-4 per day which is reasonable. With 800 discharges you should have eight physicians on your committee. These may be appointed to review only the charts of their own departments or may review charts indiscriminately as the medical staff desires. Each physician should conduct a review at his leisure, but the committee should meet once a month to discuss doubtful charts and physicians who do not follow the regulations for medical recording.

Use of Antibiotics

QUESTION: *Our physicians use just about every antibiotic in the book in this hospital. Some of them use them indiscriminately. Our department of internal medicine insists that we should withhold at least two powerful antibiotics to use only in the case of a dire emergency when nothing else will work. What is your opinion?*

ANSWER: I agree with your department of internal medicine. You should have in reserve some powerful antibiotics which are guaranteed to knock out any staphylococcus infection that should become epidemic or get out of hand. If the bacterial flora in your hospital have had exposure to all of the antibiotics, there is a possibility that they may develop resistance to all of them.

Medical Staff Committees

QUESTION: *Ours is a 25 bed hospital and there are five physicians who practice here. How is it possible for us to maintain all of the committees that the Joint Commission on Accreditation of Hospitals require.*

ANSWER: You may have one committee which combines the duties of all the required committees and you need not call it a committee but may regard it as the entire medical staff. As long as the functions of the committees are carried out, the Joint Commission will be satisfied. Your medical staff must, of course, meet once a month.

Vaginal Examinations

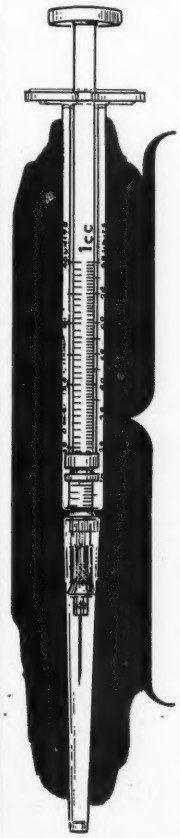
QUESTION: *Is it proper for the nurse in charge of the delivery room to perform vaginal operations on patients to find out how far advanced the patient is in labor?*

ANSWER: This is a matter of medical staff policy. First, it should be decided if vaginal examinations will be permitted at all. In some hospitals, only rectal examinations are permitted. Second, it must be decided if this is a proper function of the nurse or of a physician. In some hospitals, only physicians are permitted to undertake these examinations.

Clean and Dirty Operations

QUESTION: *We have a rule in our operating room that "dirty" cases involving infection or bacteria may not be scheduled in the operating room until all "clean" cases have been disposed of. Are gastrectomies and colon resections considered "clean" or 'dirty?"*

ANSWER: According to an item in "Queries and Minor Notes" in the *Journal of the American Medical Association,* gastrectomies and colon resections or resections of any part of the gastrointestinal tract are considered "clean". Any instruments contaminated by the gastrointestinal tract are placed in a special basin



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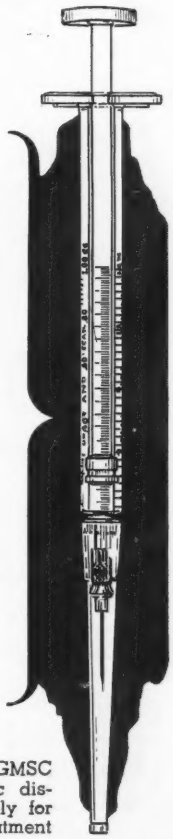

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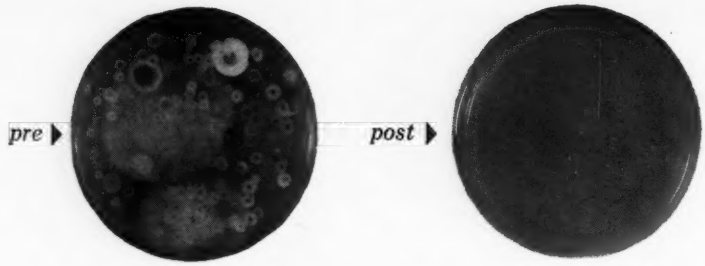

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for contaminated instruments and are not mixed on the instrument table.

Disinfection of Operating Room

QUESTION: *What is the correct method of disinfecting an operating room after an operation where pus or infectious organs have been encountered?*

ANSWER: All instruments, linens and utensils which have been used in the case should be isolated in a plastic bag which can be identified as containing infectious materials. This bag should then be taken immediately to work room for disinfection. Residual disinfectants and detergents should then be available to wash down all furniture, apparatus, floors and walls wherever there might have been a possibility of gross contamination. Several disinfectant manufacturers now also provide a fogging device which can deposit fine droplets in nooks, crannies and other inaccessible spots in the operating room. This reduces considerably the amount of time that a room must stand before it is used again. Depending upon the technique used, an operating room may be used as little as two hours after a dirty case has been operated.

Narcotic Records

QUESTION: *We understand that a list of narcotics and sedatives used in the hospital must be recorded in a special book. Where can we get such a list?*

ANSWER: You should apply to the State Board of Pharmacy for a copy of the pharmacy laws in your state. This should include the list of narcotics and sedatives of which a record must be kept.

Personnel per Patient

QUESTION: *We are setting up standards for a hospital system and we would like to know what is accepted average personnel per patient for hospitals in the United States.*

ANSWER: There is no such thing as an average personnel per patient which can be considered as acceptable. There are no two hospitals which are alike. The only significant consideration to bear in mind is the number of personnel per patient which is necessary to give a high quality of patient care.

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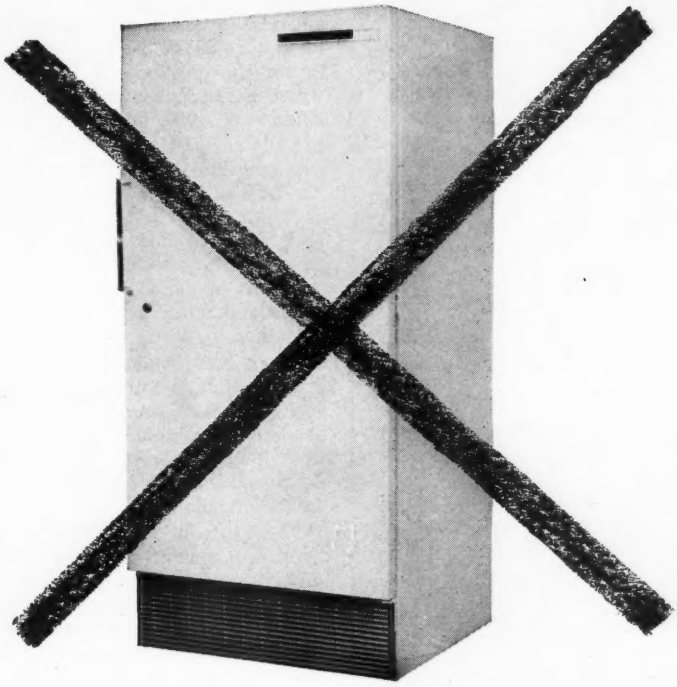

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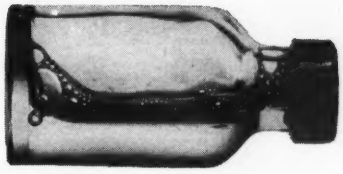

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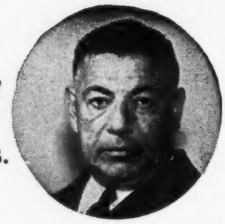
hospitals & the law



by Emanuel Hayt, LL.B.

Rule of Charitable Immunity No Longer Applicable to Paying Patients in Wisconsin

■ THE COMPLAINT alleges that on July 20, 1956, the plaintiff fractured her left hip and was admitted to the defendant hospital as a paying patient; that on that date she was sixty years of age and was mentally ill; that because of her mental and physical condition her attending physicians gave directions that the guard rails on her hospital bed be maintained in an up position; that the defendant, its agents, servants, and employees carelessly and negligently failed to provide guard rails in an up position on the bed in which plaintiff was confined and on August 27, 1956, at about 2:00 a.m. the plaintiff fell out of her bed to the concrete floor, refracturing her hip at the site of the original injury and sustaining other serious and severe injuries, to her damage. In effect the answer denies the allegations of negligence in the complaint and the extent of the injuries sustained.

After issue was joined the defendant moved for summary judgment on the ground that the defendant is a charitable institution and as such is entitled to immunity from tort liability such as is alleged in the complaint.

"The rule of stare decisis, however desirable from the standpoint of certainty and stability, does not require us to perpetuate a doctrine that should no longer be applicable in view of the changes in present day charitable hospitals. They are now larger in size, better endowed, and on a more sound economic basis. Insurance covering their liability is available and prudent management would dictate that such protection be purchased.

"The financial statement of the defendant clearly shows that the judgment for damages in the present action would not cause it to suspend its operation or to be seriously hampered therein. Under the circumstances revealed by the record we have no hesitancy in stating that we will no longer recognize the defense of charitable immunity in cases where a paying patient is seeking recovery from a charitable hospital for the negligent acts of the hospital, its agents, servants, or employees, and we hereby reverse all of our prior decisions that are inconsistent with this opinion.

"The issues raised by the pleadings will of necessity have to be tried. For that reason we agree with the trial court that there must be a trial."

(Kojis v. Doctor's Hospital 12 CCH Neg Cases 2d 118—Wis.)

County Hospital Immune From Liability for Death of Hospital Visitor

■ THE ADMINISTRATOR of Perle Oscar Bondurant, deceased, brought suit for $57,500 against the Board of

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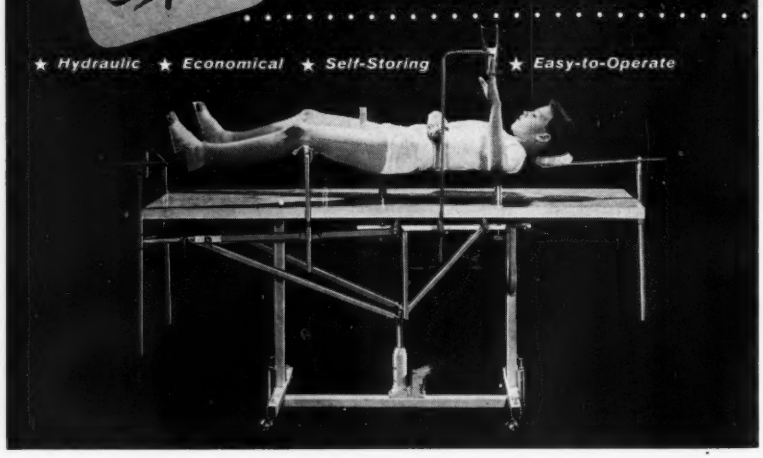

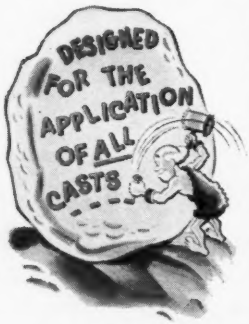

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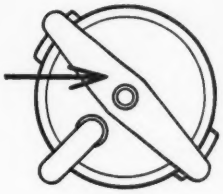

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Trustees of the Memorial Hospital of Converse County, alleging that defendant was a corporation organized under the laws of Wyoming; that deceased died on November 5, 1957, from injuries sustained on June 27 while visiting his daughter at the hospital when he opened an exit door and fell to the areaway below; and that plaintiff's claim was thereafter rejected by defendant. The answer denied generally and alleged that the screen doorway through which decedent passed was closed and fastened with three hooks, was used for ventilation, and that decedent's action in opening it was negligent. Thereafter, defendant filed a motion to dismiss on the ground that it was immune from the action under its status as a governmental agency. The trial court granted the motion.

"We are aware of the inequities which often arise by reason of the rule of governmental immunity from tort liability, and we are also cognizant of the fact that such inequities tend to be more numerous with increased governmental activities. Nevertheless, the rule by which state agencies are immune from tort liability while acting in governmental capacity is so well established in this State that any change must be effected by the people through legislative action rather than by the courts. Accordingly, the order of dismissal by the trial court was correct."

(Bondurant v. Board of Trustees, Memorial Hospital of Converse County, 11 CCH Neg. Cases 2d 653 —Wyo.)

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Immunity of Charitable Institutions in Ohio Restricted to Hospitals

■ PLAINTIFF sought relief against defendant Salvation Army for personal injuries which he received due to the tortious conduct of one of defendant's agents who was employed at "The Red Shield Lodge." When the Salvation Army was named as sole defendant, the trial court sustained defendant's demurrer to the complaint. When plaintiff amended his petition, designating the Red Shield Lodge as a new party, the trial court granted a motion to quash service on the Red Shield Lodge on the ground that it was not a legal entity but merely a name used by the Salvation Army to identify a part of its program. The actions of the trial court were based on the fact that the Salvation Army is a charitable and religious institution.

The holding that a charitable hospital is no longer immune from suit by beneficiaries of its services applies only to hospitals and not to other charitable institutions. The distinction is based on the Supreme Court's judicial notice of the fact that hospital patients pay substantially the total cost of their hospitalization. Other organizations of a charitable nature which charge fees of their beneficiaries for certain services do not lose their immunity status because the fee is only a nominal charge and in no way total compensation for the service rendered. In this case, plaintiff did not indicate how much he paid for his lodging with the Red Shield Lodge. In light of that absence of fact, this court affirmed the trial court's demurrer to plaintiff's petition.

(Bell v. Salvation Army, 11 CCH Neg. Cases 2d 1083—Ohio)

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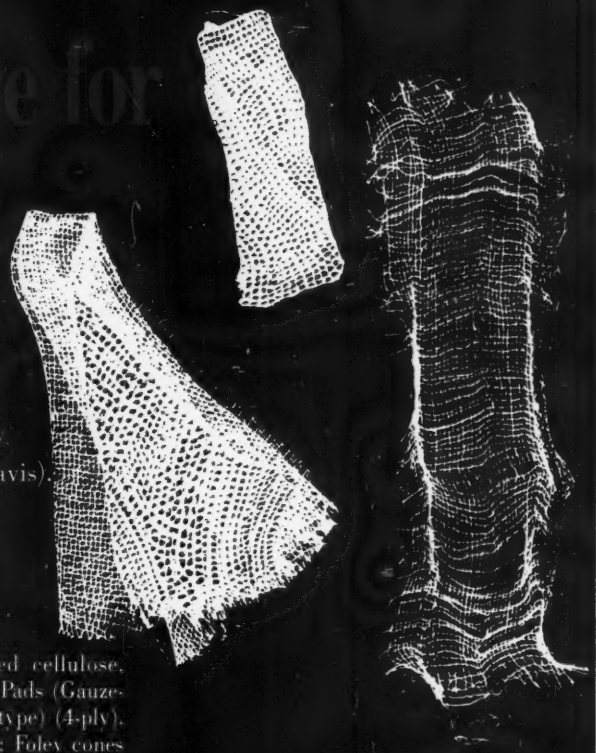
arresting measure for surgical bleeding



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Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. *Use:* Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

Precaution: Excess amounts should be removed prior to surgical closure to avoid foreign-body reaction. Not to be used in sites of infection or following silver nitrate or other escharotic chemical agents. Contraindicated in clean bone surgery when poor vascularization is present and in instances where rapid callus formation is desired. Should be used sparingly in open reduction of fractures and in cancellous bone. Will not withstand heat sterilization. Remove from container aseptically.

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MEDICAL RECORDS

by Adeline C. Hayden, C.R.L.

X-Ray Films in Court

***QUESTION*: What responsibility does the medical record librarian have in taking x-ray films to court in answer to Subpoena Duces Tecum and getting them back from the exhibit room at the end of the trial?**

ANSWER: If you receive a Subpoena Duces Tecum, this means—come and bring with you whatever is listed on the Subpoena. If you take the x-ray films along with the medical record you are responsible for their return. I would suggest that you check your state laws to determine if copies of x-ray films are acceptable in court. You know, x-ray films can be reproduced and if the reproductions are acceptable my advice would be to present the copies. Even though the copies are signed for by the clerk of the court, follow through and see that the copies are returned. If you hold a signed receipt you have every right to insist upon the return of the copies.

Tumor Registries

***QUESTION*: Will you please tell me the specific requirements relative to Tumor Registries within a hospital? Is it desirable to set the Registry up as a separate department or make it a part of the medical record activities?**

ANSWER: May I suggest that you write directly to the American College of Surgeons, 40 East Erie Street, Chicago, Illinois and ask for the booklet relative to the establishment of a Tumor Registry. As for the location of the registry, it may be set up either as a separate department or in the medical record department. In a large hospital where the record department is very active, I would suggest a separate department for the registry. Of course the individual who is in charge of the registry must comply with the rules and regulations set up for use of the medical records and work very closely with the medical record librarian.

Formula for Infant Death Rate

***QUESTION*: What is the formula for determining infant death rate percentage?**

ANSWER: The formula is newborn deaths times 100 over live births.

$$\frac{\text{newborn deaths} \times 100}{\text{live births}}$$

Rehabilitation Hospital

***QUESTION*: In a Rehabilitation Hospital should we code the original accident and the residual?**

ANSWER: I see no reason to code the original accident unless the hospital wants it for some special

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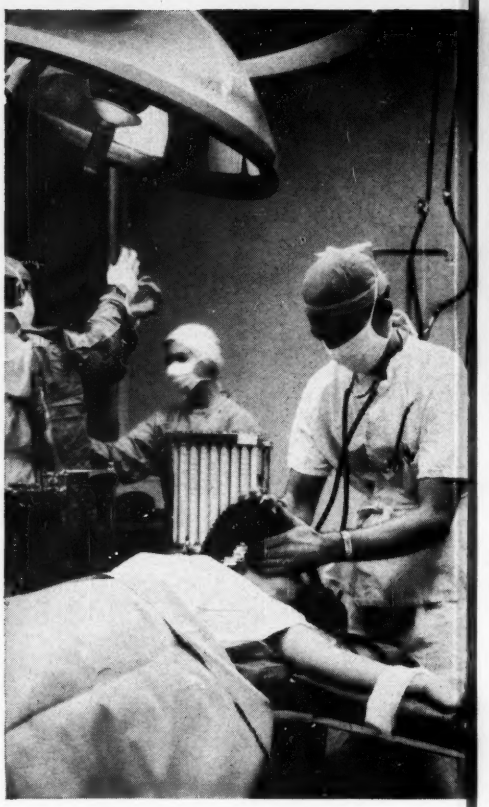

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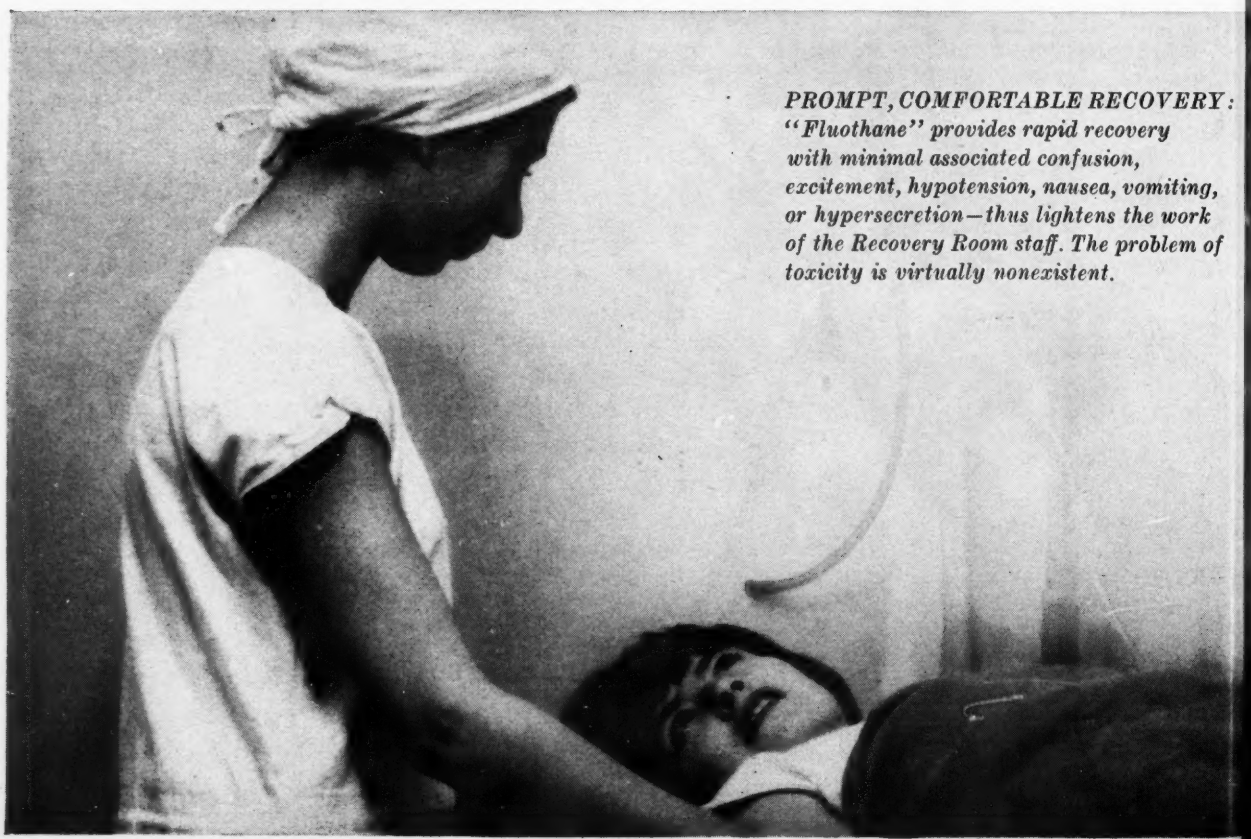

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record. The residual of the original accident should be coded in your clinical index — for example, if the patient is injured in a diving accident and later develops transverse myelitis. What you are actually treating the patient for is the transverse myelitis; the fact that the patient was injured in a diving accident is purely statistical and should be noted in your medical record but not your clinical index.

I.B.M. and Standard Nomenclature

***QUESTION*: We are contemplating installing International Business Machines in our hospital and the administrator is desirous of using machine indexing. We use Standard Nomenclature and have been informed that the Nomenclature is not suitable for I.B.M. equipment. Please let me know if this is exact?**

ANSWER: You certainly have been misinformed. Your informant knows neither I.B.M. or Standard Nomenclature. From actual experience I know Standard Nomenclature is applicable to I.B.M. even with the most specific coding. When Standard Nomenclature was started in 1928 mechanical indexing was considered. At least two important aspects are involved (1) know what you want from the machines, they can only give you what you provide for (2) work with the I.B.M. representative. He does not know disease indexing and you cannot expect him to do the work alone, but he can give you what you want if you guide him. Think of the fields in which letters will fall, how duplicates can be prevented in both Serial and Unit Systems and many other details which enter into the picture. Discuss all of these details with the representative and the installation will be effective and efficient. All that is needed is "know how." Don't be deceived.

Cast Charges

***QUESTION*: The Chairman of our Record Committee has asked me to write you for advice on a method to be used for classifying in a disease classification those patients who are admitted for change of cast only.**

ANSWER: If you especially want to include cast changes in your disease index, it is suggested that you use the code for Observation only on page 484 of the Nomenclature. If you wish to do so, you may change the first three digits to indicate the bone or bones involved.

Undelivered Dismissals

***QUESTION*: When a patient comes into the hospital for delivery and is dismissed undelivered, is it necessary to have the history and physical completed?**

ANSWER: By all means the chart should carry the usual complete history and physical. You have no assurance the patient will return to the hospital. If the patient does return within one month, all that is necessary is an interval note.

Cross Indexing

***QUESTION*: If four diagnoses and three operative procedures are listed on the identification sheet and we do not cross index, is it necessary to index more than just the first diagnosis and the first operation listed.**

ANSWER: All diagnoses listed as final diagnoses must be indexed and all operative procedures listed must be indexed. Simple straight indexing is all that is necessary, you do not need to cross index one to the other.

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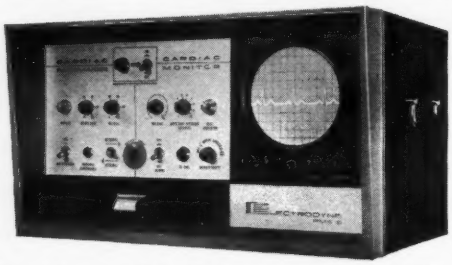

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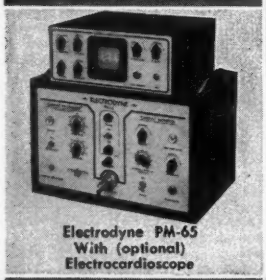

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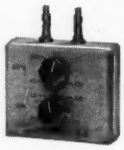

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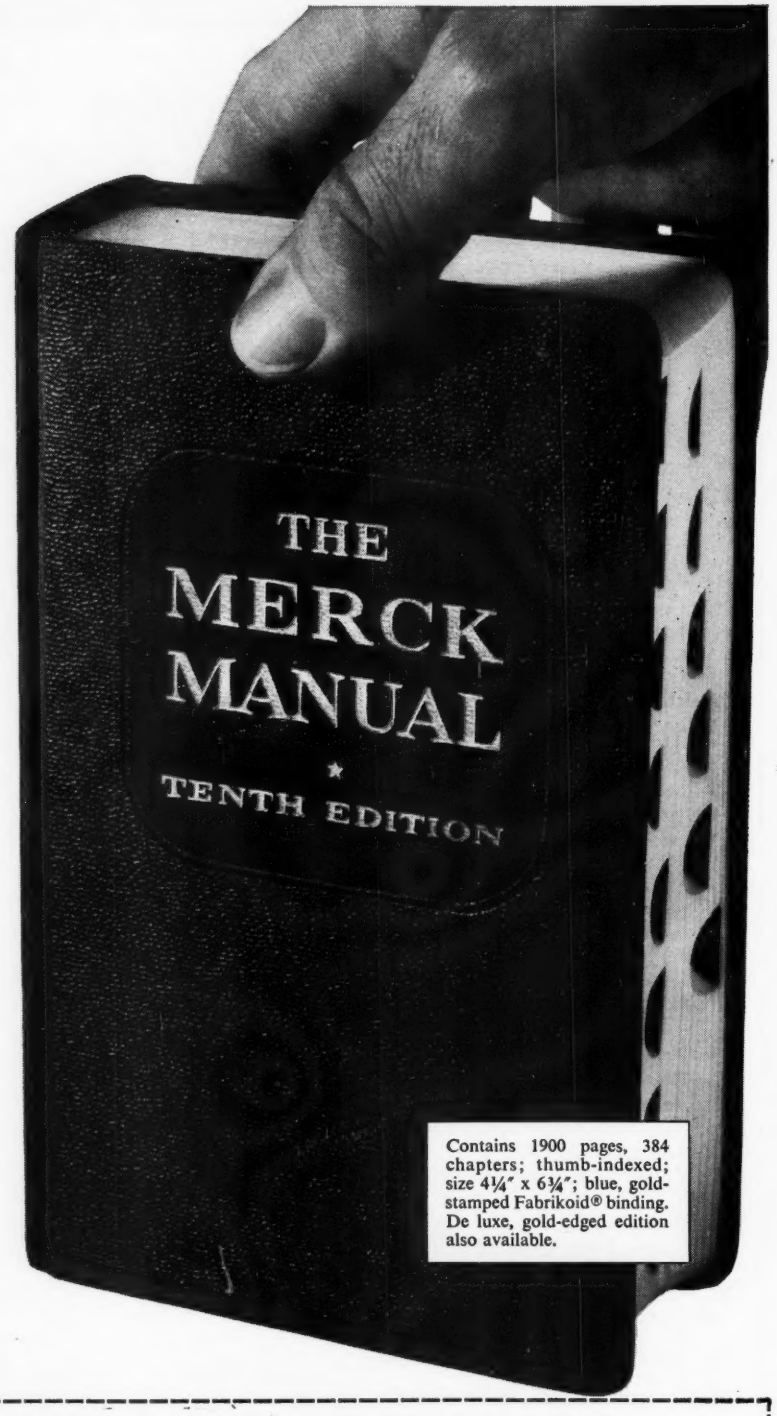

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To what extent does the construction of hospital facilities in a particular area reflect the existence of a "community" in that area, i.e., an identifiable, concentrated population grouping?

Are hospitals established in response to a need as expressed by inhabitants of the area in which the institution is located?

Does the hospital, once in operation, receive its support largely from this group and does it exist for the major purpose of serving the health needs of this group?

What relationship do similarities and distinctions in patterns of hospital growth and development in different areas have to the particular stages of growth and development characteristic of the areas concerned?

Patterns of Hospital Development in the Western and San Fernando Valley Areas of Los Angeles County

Hospital Development and Communities

by Beatrice Dinerman

Bureau of Governmental Research
University of California
Los Angeles, California

■ INQUIRIES in the field of hospital growth and development have usually been directed toward the internal operations of these institutions, the availability of an adequate number of hospital beds in accordance with professional group recommendations, or the extent to which selected hospitals adhere to a set of medically approved professional standards in the provision of their services. Little attention has been given to the hospital as a "community" institution whose establishment reflects a concentrated population growth with a concomitant need for hospital facilities to serve the health needs of an increased number of inhabitants.

The absence of substantive studies in this area of inquiry prompted the Bureau of Governmental Research at UCLA to conduct a comprehensive investigation of patterns of hospital development in two sections of Los Angeles County. The selected areas, moving through different stages in the process of community maturation, lend themselves to a comparative approach. The San Fernando Valley represents an "adolescent" area characterized by a recent impressive population growth which, in all likelihood, will continue to proliferate in the near future. The western section of the county is representative of a more mature area which has reached a point of relative stability in terms of population growth.

This study, limited to nongovernmental, proprietary hospitals offering general-type hospital services, was based, in large part, upon data obtained through interviews with hospital administrators charged with managing hospitals presently operating in the Western and San Fernando Valley areas of the county. It represents an attempt to cast greater light upon the nature of communities through an analysis of the extent to which patterns of hospital growth and development reflect, or fail to reflect, the existence of distinct, identifiable community areas within the larger metropolis.

The investigation was necessarily based upon a number of initial assumptions which tended to direct the inquiry along certain lines.

- It was assumed that a correlation could be found between the establishment of a hospital in a specific area and the presence of a community in that area.
- The assumption was made that hospitals are generally constructed as a matter of personal convenience

This article is a condensation of Miss Dinerman's recently published study "Hospital Development and Communities" conducted by the Bureau of Governmental Research, University of California at Los Angeles. Copies available from The Bureau of Government Research, $1.30 per copy.

for physicians practicing from offices in the vicinity. This desire, on the part of physicians, for hospital facilities geographically close to their respective offices is reflected in the increasing number of hospitals established and owned by groups of private physicians.

● It was assumed that a physician's desire to establish his practice in one particular area, as opposed to another, is influenced by the extent to which the selected area is populated by a large enough potential clientele to assure a reasonable degree of professional success. In this manner, substantial population growth in a particular area induces physicians to establish and maintain their practices in this area. These physicians, once established, require hospital facilities near their offices as a matter of convenience. Therefore, it was inferred that hospitals are generally found within areas whose population growth might well characterize them as "communities."

A number of specific areas of investigation were pursued in an attempt to verify or negate the validity of these assumptions. It was initially recognized that information would have to be obtained regarding the rationale behind the selection of a paticular site for the construction of hospital facilities, the source of initiative for hospital establishment and the size and facilities of hospitals under investigation. The relationship between population growth, increases in the number of practicing physicians and hospital construction in specific local name areas over a period of years was another essential aspect of this survey. Considerations pertaining to the type of ownership involved emerged as an important by-product having a basic impact upon the initial assumptions.

Number, Size and Facilities of Hospitals

The Valley area, inhabited by some 680,000 persons, is served by 11 hospitals as opposed to 13 hospitals serving a Western area population of some 800,000. However, hospital service coverage in the Western area is even greater than these figures indicate by virtue of the size of hospitals in this section of the county and the extensive facilities provided. Valley hospitals are characteristically small, with the average hospital providing 72 beds and with seven of the 11 Valley hospitals providing less than 75 beds. Western area hospitals, on the other hand, provide an average of 145 beds, with four of the 13 hospitals in the area in a position to accommodate over 250 persons and three additional hospitals able to accommodate over 100 persons. In addition, a number of hospitals in the Western area possess extensive, specialized equipment which enables them to render highly specialized medical and surgical care. There are, at present, few comparable facilities available in Valley hospitals.

Site Selection and Initiative

Investigation revealed a close correlation, in both sections of the county, between population growth, lack of adequate hospital facilities in the area and a need for hospital facilities located geographically close to doctors' offices. These elements were emphasized as determining factors by hospital administrators. Considerations pertaining to transportation convenience and the absence of traffic noises and other disturbing elements, though mentioned occasionally, were deemed of secondary importance in determining hospital locations.

The correlation between hospital construction and a need for hospital facilities in close proximity to physicians' offices is exemplified by the vociferous role played by physicians of the community in providing initiative for the establishment of hospital facilities in their respective communties. The predominant importance of physician demands, in both sections of the county, in stimulating and encouraging the construction of hospitals as a matter of personal convenience indicates a strong relationship between practicing physicians and the growth of hospital facilities designed to serve their needs.

Growth of Population, Physicians and Hospitals

Population growth generally occurs prior to an increase in the number of physicians as evidenced by a gradual decrease in the number of persons per physician despite a consistently impressive population growth. Hospital construction tends to lag even further behind. These patterns are reasonable in the light of a hesitancy, on the part of physicians, to establish their practice in a particular area until the area is inhabited by a sufficiently large and stable population to assure a reasonable degree of professional success. An even greater time lag in hospital construction can be similarly explained with reference to the large capital outlay involved in the construction of a hospital and a reluctance to assume the financial risks involved until such time as the area under consideration possesses a large enough number of potential patients and physicians to support its services.

Turning to patterns of hospital development in specific communities, one finds a similar correlation between increases in population, physicians and hospitals. Earliest hospital construction first took place in those communities first characterized by a population-physician growth which far exceeded similar growth patterns in neighboring areas. Additional hospitals were subsequently established in communities of more recent, impressive population growth. Yet, in other cases, population trends in the immediate vicinity would seem to have no direct bearing upon the decision to construct a hospital. A prior analysis of population and physician growth trends over a *wider* area, however, preceded construction of all hospitals under investigation.

Hospital Coverage

Anticipated and actual service coverage is one of the few criteria which clearly exemplified the relative "community-orientation" of hospital institutions. A majority of Valley hospitals, according to hospital administrators, were erected for the express purpose of serving specific Valley communities. It is significant to note that unlike Valley hospitals which had anticipated drawing a major portion of their clientele from fairly small community areas, a majority of Western area hospitals indicated an initial intention to serve broader regions as opposed to specific communities within these regions.

Actual service coverage of Western and Valley hospitals after they had been in operation for a period of time is even more significant. Some 85 percent of the patients treated at Valley and Western hospitals reside within a ten-mile radius of the hospital. The physician picture is even more striking. It should be noted that hospitals generally view the physician, not the patient, as the client or potential client utilizing their services. With certain exceptions, a patient generally patronizes the particular hospital recommended by his physician.

The physician, in turn, selects hospitals in the light of his own convenience and the extent to which particular hospitals live up to a set of professional standards which he feels essential. Some 95 percent of physicians affiliated with Valley and Western area hospitals practice from offices located within a ten-mile radius of the hospitals with which they are affiliated. This picture clearly exemplifies the highly localized nature of hospital services, with patients and physicians rarely traveling beyond a ten-mile radius to utilize hospital facilities.

Smaller hospitals tend to draw their patients and physicians from a more limited area than larger institutions which generally enjoy a more regional coverage. Extensive equipment, ability to accommodate a larger number of persons and the prestige and confidence associated with these regional hospitals are some bases for a willingness, on the part of both patients and physicians, to travel some distance in order to utilize the facilities of these institutions. However, it should be noted that larger regional hospitals too draw a majority of their patients from within a ten-mile radius.

Occupancy Percentages

One of the most interesting findings derived from this investigation relates to the relative success of the hospitals surveyed. Significantly, the relatively high occupancy percentages of most Western area hospitals is diametrically opposed to vacancies evident in a number of hospitals located in the Valley, indicating that population is not the sole factor to be considered in determining hospital needs and utilization. If population were the only factor involved, Valley hospitals located in an area of tremendous population growth and a deficient number of hospital beds would be filled to capacity. Yet, in reality, it is the Western area hospitals, situated in a county region with a less impressive recent population growth served by a relatively sufficient number of hospital beds that gives evidence of slightly higher occupancy percentages. Investigation revealed this situation to be the product of a number of interrelated factors.

The comparative success of Western area hospitals can be attributed to a large and stable population, a generally older group of inhabitants requiring more frequent hospitalization and advances in transportation convenience which enable persons to cover greater distances in shorter periods of time in order to utilize the hospital of their choice. Greater utilization of Western area hospitals can be further explained in terms of the length of time these hospitals have been in operation and the highly extensive facilities provided. Ten of the 11 Valley hospitals have been constructed during the past ten years. They have not yet had the opportunity to cultivate a loyal clientele comparable to that enjoyed by Western area hospitals. Furthermore, Valley hospitals are characteristically small and all but two have limited facilities. As a result, Valley physicians and patients tend to make greater use of Western area hospitals, with Western area patients and physicians less prone to utilize the facilities of hospitals located in the Valley. It is conceivable that several decades of continued population expansion will produce a Valley Hospital pattern similar to that presently found in the Western section of the county. Recent construction of several large, extensively equipped hospitals in the Valley area represent an observable shift in this direction. For the first time in the history of the Valley, nonprofit hospitals are being erected which are similar to the larger Western area hospitals in terms of their anticipated regional coverage, the extensive facilities provided and their ability to accommodate an expanded clientele.

Trends in hospital ownership have also had an impact. Over half of the hospitals established in the Valley are owned in whole or in part by practicing physicians. According to hospital administrators, this situation has accentuated existing rivalries among medical groups practicing in the Valley to the detriment of the hospitals themselves. Close to 40 percent of the hospitals in the Western area, on the other hand, are nonprofit institutions, accounting for some 70 percent of the total hospital beds in this section of the county. The absence of numerous competing physician-owned hospitals has allegedly eliminated at least one potential source of conflict. Physicians tend to regard nonprofit institutions as neutral entities. Hospital ownership by a group of physicians might assure the hospital a certain number of patients brought to it by the group or by close associates of members of the group. However, hospital administrators feel an even greater number of physicians might refuse to patronize the hospital due to personal or professional jealousies or rivalries with one or several investors closely associated with the institution.

Hospitals: Regional or Local Institutions?

The establishment of *any* service institution reflects the existence of a "community" in the area if

1. It is established in response to a felt need as expressed by inhabitants of the area in which the institution is located;

2. These inhabitants constitute a group large enough to support its services;

3. It receives its support largely from this group and exists for the major purpose of serving the needs of this group.

Applying these criteria to the establishment and operation of hospitals, one finds that

1. They *are* established in response to a felt need as expressed, in this case, by physicians practicing in the area. This area rarely exceeds a five-mile radius though it is generally greater than the boundaries of the local name-community in which the hospital is to be located;

2. Inhabitants of the immediate vicinity do not always constitute a group large enough to support its services. Rather, many hospitals are dependent upon the support of a clientele drawn from a wider area, though this area rarely exceeds a ten-mile radius;

3. Hospitals do not generally exist for the major purpose of serving the health needs of inhabitants in the immediate vicinity in which the hospital is located. However, clientele is rarely drawn from a radius in excess of ten miles.

It would seem that hospital care represents one type of service with no exclusive relationship to the community in which the services are rendered. Yet, there would seem to be a definite relationship between the hospital, the community in which it is located and a small number of adjacent communities, with total service coverage rarely exceeding a ten-mile radius. Excessive travel time and the existence of reputable hospital facilities in closer geographical proximity to physicians and patients prevent hospitals from having a truly county-wide coverage. ■

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The pressure of the patient who is able to demand and get the best service because, with the help of his health insurance, he pays his own way, is not yet fully appreciated by hospitals or by patients. Unless we soon learn to appreciate it and use it, we shall lose it in a very costly system of so-called "free" care. If that happens, a very powerful force toward quality of hospital care will have been destroyed.

by Albert V. Whitehall

Director of Health Insurance
Life Insurance Association of America
New York 22, New York
and
Vice Chairman, Health Insurance Council

■ INCENTIVES have a lot to do with things we do; why we do them better; or why we do things at all. The history of hospitals illustrates the influence of incentives on the quality of hospital services.

The earliest hospitals in our culture were maintained by cities or towns. They were havens for the dregs of humanity—poorhouses for the indigent, the aged, the crippled, as well as the insane and the diseased. One of the hazards of travelling in those days was that if you became ill or injured in a town where you had no friends, you had no other place to go but the town hospital.

These were government hospitals, and we still have vestiges of them in our mental hospitals and some other institutions where the incentive is simply to provide a necessary service at a minimum of money. I suspect that the incentive for the earliest hospitals was the social necessity of getting these cripples off the street. Until recently, I am sure, the principal motivation for our mental hospitals seems to have been little more than social expedience; seldom have our state governments provided enough money to permit good care.

Even in our own enlightened era, we have human beings in so-called hospitals, where the tax funds appropriated by state government are hardly enough to purchase food, let alone good care. I am happy to say that recent drug discoveries have given us new hope and new incentives for better care of our mental cases. Until then, it seemed that our attitude toward these unfortunates was: "We can't put them out of misery as we do animals, but let's at least get them out of sight; and let's not spend anything on them that we don't have to."

This is the incentive I have called social expediency—"society's obligation." It is the incentive that motivated our earliest government hospitals.

Then the voluntary hospitals began in England. The incentive was humanitarian. Groups of citizens banded together to raise funds for hospitals that would give better care than the existing town or city institutions. The name "voluntary" indicated the change: the old tax-supported hospitals existed because they had to be; the new voluntary hospitals existed because they wanted to be.

The humanitarian incentives that produced the voluntary system, produced in our voluntary hospitals a quality of service the world had never seen. The voluntary hospitals were transplanted to the New World when our nation was settled. In this continent a church hospital in Quebec, and a hospital founded in Philadelphia by a group of citizens were among the earliest examples. Benjamin Franklin was one of the first hospital trustees.

Our voluntary hospitals have been the core of our hospital system since our country was founded. Voluntary hospitals today are of three main types, indicating the range and variety of the voluntary system.

1. Nonprofit community hospitals are probably the largest group. These hospitals are governed on behalf of the community by hospital trustees, outstanding citizens who serve without pay as a community service. In recent years, communities have used bond issues or tax funds to build community hospitals, but operate them as voluntary hospitals for the public as a whole and not solely for the indigent. These, while not technically "voluntary," might be properly classed as such.

2. Church hospitals, though less numerous than the secular nonprofit group, have had great influence on the voluntary system. Church sponsorship includes many Catholic orders and many Protestant denominations.

3. Proprietary hospitals are a

small segment of the voluntary hospitals, with less than 10 percent of hospital beds and with rather limited range of services, as a rule. They are voluntary in the sense that they provide services that would otherwise be required from government. They differ from the other hospitals by operating for profit and not being exempt from taxes.

Our voluntary system today is a fine tribute to the second incentive that I have in mind—humanitarianism. The high quality of our hospital care is the result of the philanthropy, altruism and ideals of many citizens who have contributed money and time to the service of their fellow men. This motivation lifted hospital care beyond the level attained by hospitals whose only purpose was necessity and the compulsion to society.

The Customer

Now, at last, I come to the topic of this discussion—a third incentive, which has thus far been unappreciated. To describe this "unappreciated incentive", I must discuss a new character in our story of hospital progress—the patient who pays for the care he gets—"the customer."

The pay patient is new. The pay patient existed rarely, if at all, before World War I. It was about that time that surgery began to offer a better than 50 percent chance of success. It was about that time that the Flexner study shook up the medical school system, bringing radically new standards. Hospital care became safer than home care, and more convenient and respectable. People who would have felt disgraced to have to resort to a public hospital for care, now found the hospital a desirable and necessary community service.

Hospitals still have not learned how to charge the pay patient properly. The difficulties and confusions are enormous. When hospitals had no pay patients, the actual cost of patient care did not matter. Uniform accounting, cost accounting, rate setting and collections have been complicated unbelievably by philosophic issues that would never occur to the average businessman. Granted that each patient should pay the actual cost of his own care, what is that cost? Each case is different, few procedures are routine. The time-study, engineering methods for determining production costs are difficult to apply to personal services where the nature of the illness, and indeed the nature of the patient, are infinitely variable.

Granted that you could determine unit cost, how do you charge the public properly? Only within the last dozen years have some eastern hospitals had to abandon the practice of charging higher than cost for private rooms to subsidize ward beds for which the published rates were less than cost. Even today, hospital administrators point out that Blue Cross negotiated rates result in loss of income to the hospital and a deterioration in the quality of care, unless it is possible to make up these deficits from other income. Government agencies traditionally have driven a hard bargain with hospitals for care provided to the indigent and others for whom government should be responsible. Hospitals, thus, have never been able to set their rates on the logical basis of cost plus a reasonable mark-up because they do not have control over whom they will accept as patients. Hospital charges have had to be established with at least one eye on keeping the front door open 24 hours every day.

Complicate these pressures with constantly rising wages and shorter hours for hospital workers who traditionally were underpaid and overworked when hospitals were purely charitable. Add an intricate maze of new scientific services and paramedical and professional skills to keep pace with the latest life-saving discoveries of medical science; pay these new workers even higher wages than the former employee of lesser skill. Take into account the increasing number of court decisions making nonprofit hospitals responsible to their patients for damages due to negligence (purely charitable hospitals were exempt from such liability). These and many other new categories of expense have added to hospital costs. But hospital care has become better for everyone through the influence of those who do pay for it.

In fact, hospital care has acquired some aspects of luxury comfort and convenience that would be extremely unlikely under a system of "free" or purely charitable hospitals. What about our landscaping, luxurious lobbies, interior decorating and other aesthetic evidences in today's hospitals? What of the trend from ward care to more semiprivate and private rooms, and the increase of personal services such as choice of menus. What of telephones, radio and television, air-conditioning in patients' rooms? Are these basic essentials of necessary hospital care? Or do they represent efforts to please the paying customer? Granted that such creature comforts may accelerate healing, would they normally be part of hospital care limited to the "free" patient?

When hospital care was totally charitable, the patient took what he got. If hospital care becomes "free," the patient will have little to say about the service he gets. But when a patient pays his own bill—out of his own pocket or with the help of insurance—inevitably he forms an opinion as to whether he got his money's worth. The psychology is subtle but definite. The patient has the confidence to demand his money's worth. Hospital personnel become aware that the patient is not just a taxpayer or an object of charity, but an influential customer who must be satisfied because he is paying for it.

Sale of Services

Today it is not uncommon for 90 percent or more of hospital income to come from the sale of hospital services to patients. The charitable incentive continues to influence hospital care; so does the obligation of society as expressed through government programs. Each of these strong influences has been added to the others in turn, to produce in our country the finest, most luxurious, most effective hospital care the world has even known.

The most recent of these incentives may also be the most temporary if we do not quickly recognize it and learn to use it. In the merchandising world "the customer is king" and he knows it. The discriminating purchaser uses his power to draw better goods and services into the market. In the hospital, the patient and the general public must be made aware that their purchasing power, too, forces hospitals to provide the highest possible standards of care.

The Incentive

Our third incentive—the pressure of the patient who is able to demand and get the best service because, with the help of his health insurance, he pays his own way—is not yet fully appreciated by hospitals or by patients. Unless we soon learn to appreciate it and use it, we shall lose it in a very costly system of so-called "free" care. If that happens, a very powerful force toward quality of hospital care will have been destroyed. ■

by Charles U. Letourneau, M.D., Melinda Ulveling and Patricia Heuser

Hospital Costs

Analysis of hospitals over 500 beds

Influence of *outpatient visits*
***residency programs* and**
accredited schools of nursing

■ PEOPLE who are seeking to pin point the factors in the increasing cost of hospitalization should consult the figures which are readily available for their study.

In November and December, 1960, we published a study* of hospitals over 500 beds in the United States and attempted to correlate factors with the reported costs of each hospital. These studies were made on the basis of figures published by the American Hospital Association in the Administrator's Guide Number of *Hospitals* (August 1, 1960).

As we pointed out at the end of our study, there were ten other factors which we identified as having a bearing on hospital costs where figures were not available.

Subsequently we consulted the internship and residency number of the *Journal of the American Medical Association* (October 8, 1960) in which is reported the number of outpatient visits in each hospital offering internships and residencies. The number of residencies and internships in each hospital is also reported. We also consulted *"Facts About Nursing,* 1960" for a list of schools of nursing accredited by the National League for Nursing in each hospital.

In order to obtain even greater accuracy, hospitals over 500 beds were requested to furnish figures of the number of outpatient visits in their hospitals for the year 1960. Most of them did. The others stood by the figures which they reported to the American Medical Association.

Although the results reported here cannot be taken as a precise account of the effect of these factors upon costs of hospitalization there is enough correlation between costs and the factors mentioned in this study to be of significance to the hospital field.

As a variation from our previous study, the norm of determination of costs was taken as the cost per patient day instead of the expense per admission as previously reported.

Summary

There seems to be no doubt that outpatient visits do definitely influence the cost per patient day of a hospital. How much or how little this influence is exercised is difficult to say. The same observations might be made of the number of residencies and internships.

It is not our purpose to draw a comparison but simply to point out that it is a dangerous practice to attempt to pick even several factors as the reason for the per diem costs of a hospital without having all of the factors at one's disposal.

Since there are no two hospitals which are exactly alike, there does not seem to be any basis at this time for devising a formula for standardizing hospital costs. Further research should be undertaken. ■

Melinda Ulveling was formerly editorial assistant with Hospital Management and Patricia Heuser is staff researcher, University Management and Secretarial Service, Chicago.

*Hospital Costs — Some Influential Factors.

Hospital Costs

Hospital Management Reprints Available

Vacant Hospital Beds—A Study of Occupancy .....50 cents each by C. U. Letourneau, M.D. and M. Ulveling

Hospital Costs—Some Influential Factors .....25 cents each by C. U. Letourneau, M.D. and M. Ulveling

The Control of Hospital Costs ....10 cents each by C. U. Letourneau, M.D.

See page 43 for State and Local Hospitals
See page 44 for VA Hospitals

Table 1. Fifty-eight Nonprofit Hospitals

Nonprofit Hospitals	Cost per Patient Day	Outpatient Visits	Residencies (No.)	Internships (No.)	NLN Accr.
Henry Ford, Detroit, Mich.	$65.15	552,777	278	26	+
Presbyterian-St. Luke's, Chicago, Ill.	54.05	123,713	111	39	+
Massachusetts General, Boston, Mass.	52.57	225,256	150	30	+
University of Chicago Clinics, Ill.	46.88	175,006	150	44	—
Presbyterian, N. Y. C.	46.20	421,464	253	27	—
Grace, Detroit, Mich.	45.43	24,526	54	24	+
University Hospitals, Cleveland, Ohio	45.07	153,173	166	45	—
Washington DC Hospital Center	45.01	78,046	80	42	+
Society of N. Y. Hosp. N. Y. C.	43.87	224,730	180	41	—
Johns Hopkins, Baltimore, Md.	43.83	386,083	194	64	+
Rhode Island Hospital, Providence	41.03	50,341	68	20	+
Harper, Detroit, Mich.	40.62	68,252	90	28	+
Albany Hospital, N. Y.	40.20	54,732	120	36	—
Grace-New Haven, New Haven, Conn.	39.86	91,915	139	45	+
Hartford Hospital, Conn.	39.85	48,150	93	18	+
Michael Reese, Chicago	39.78	43,701	118	42	+
St. Luke's, N. Y. C.	39.34	112,299	74	21	+
Methodist, Indianapolis, Ind.	39.28	80,418	43	19	+
Chicago Wesley, Chicago, Ill.	39.18	57,651	51	24	+
Mount Sinai, N. Y. C.	39.15	258,000	163	36	+
Sacred Heart, Spokane, Wash.	37.46	11,220	14	15	+
St. Francis, Hartford, Conn.	36.73	19,042	34	13	+
Akron City, Ohio	36.28	33,638	46	24	+
Baylor University Medical Center, Dallas, Texas	36.18	11,494	51	21	—
Montefiore, N. Y. C.	36.13	37,571	105	36	—
Hermann Hospital, Houston	34.36	93,057	56	18	+
Hospital of the University of Pennsylvania, Philadelphia	34.05	155,663	211	32	+
Duke, Durham, N. C.	33.48	108,679	229	58	+
Hillcrest Medical Center, Tulsa, Okla.	33.27	18,943	21	19	+
Barnes, St. Louis, Mo.	33.01	221,947	214	45	+
St. Vincent's, N. Y. C.	32.88	145,999	87	34	+
Maimonides, N. Y. C.	32.21	52,797	54	36	—
Allegheny General, Pittsburgh	32.06	107,748	30	18	—
Youngstown Hospital, Ohio	31.03	10,723	55	24	—
Aultmann, Canton, Ohio	30.65	4,820	32	20	+
Western Pennsylvania, Pittsburgh	30.14	28,920	20	18	+
St. Elizabeth, Youngstown, Ohio	29.71	17,023	35	19	+
Buffalo General, N. Y.	29.44	53,000	81	26	+
Miami Valley, Dayton, Ohio	29.40	8,634	27	16	+
Good Samaritan, Cincinnati, Ohio	29.34	15,901	37	19	+
Allentown Hospital, Pa.	29.06	23,513	16	14	+
Hahnemann, Philadelphia	28.85	80,795	102	16	+
Baptist Memorial, Memphis, Tenn.	28.53	82,984	41	21	+
Millard Fillmore, Buffalo, N. Y.	28.15	18,443	40	15	+
Albert Einstein, Philadelphia	27.20	122,000	17	39	+
Rochester Methodist, Minn.	27.11	1,635	....	....	+
St. Vincent's, Worcester, Mass.	26.42	15,580	31	18	+
Jefferson, Philadelphia	25.83	114,257	115	32	—
Reading Hospital, Reading, Pa.	24.27	20,592	36	14	+
Mercy, Pittsburgh	24.26	37,660	48	12	—
Temple University, Philadelphia	23.47	159,785	140	....	—
St. Francis, Peoria, Ill.	23.23	10,757	20	18	—
St. John's, Tulsa, Okla.	23.05	16,538	18	12	+
Creighton Memorial, Omaha, Neb.	22.86	6,054	45	18	+
Harrisburg Hospital, Pa.	22.39	45,981	23	24	—
Greenville General, S. C.	22.32	58,682	19	24	+
St. Francis, Pittsburgh	21.51	63,405	34	22	+
Harrisburg Polyclinic, Pa.	20.90	22,521	12	18	—

NLN — Accredited schools of nursing.

State and Local Hospitals

Outpatient Visits

Although the correlation between costs and outpatient visits was as valid in this group as in the nonprofit hospital group, it was not so dramatically demonstrated. Of the 20 top hospitals in this group, classified according to cost per patient day, 11 were also in the top 20 in the number of outpatient visits.

Strangely enough, however, the top six hospitals in numbers of outpatient visits were below the top 10 hospitals in the cost per patient day group. Thus, Los Angeles County Hospital with 618,601 visits rated 21 in the cost list and Charity Hospital in New Orleans rated 51 in the cost list with 567,380 outpatient visits. Both exceeded the total of the highest nonprofit hospital.

Residencies

University Hospitals of Ann Arbor lead the hospitals in this group with 337 residencies, while Charity Hospital of New Orleans was second with 329 residencies. Both exceeded the top nonprofit hospital total. In relation to costs, the correlation was significant. Out of the top 20 hospitals in the cost bracket, 11 were among the top 20 hospitals in numbers of residencies offered.

Internships

Los Angeles County Hospital offered 160 internships to lead this group of hospitals. Five hospitals in this group topped the highest nonprofit total. Ten hospitals out of the top 20 hospitals in cost ranking were also among the top 20 in numbers of internships offered.

Accredited Schools of nursing

There were 12 hospitals listed among the top 20 on a cost per patient day basis which reported schools of nursing accredited by the National League for Nursing.

Nonprofit hospitals

Table 1 lists nonprofit hospitals in order of their cost per patient day as calculated in our previous study.

Outpatient Visits

As noted in our previous study, the Henry Ford Hospital had the highest cost per patient day among nonprofit hospitals but also has the largest number of outpatient visits (552,777), about 130,000 visits a year more than the second hospital —Presbyterian Hospital of New York City which reported 421,464 visits.

Out of the top 20 nonprofit hospitals in cost per patient day, 11 were also among the top 20 hospitals in numbers of outpatient visits. All of the top 20 hospitals reported outpatient departments in excess of 24,000 visits per year.

Residencies

Henry Ford Hospital also led the nonprofit hospitals in the number of residencies offered with 278. Presbyterian Hospital in New York City was second with 253. Out of the top 20 cost per patient day hospitals, 13 were also among the top 20 offering the largest number of residencies. Each of the top 20 hospitals offered more than 40 residencies.

Internships

A correlation between internships at cost per patient day was also noted. Of the 20 top hospitals in cost per patient day, 12 were also among the top 20 offering the greatest number of internships. All of the hospitals in this group offered 18 or more internships. Johns Hopkins Hospital offered the largest number, 64.

Accredited Schools of Nursing

Among the top 20 hospitals in cost per patient day, 15 maintained schools of nursing accredited by the National League for Nursing.

Table 2. Fifty-three State and Local Government Hospitals

State and Local Government Hospitals	Cost per Patient Day	Outpatient Visits	Residencies (No.)	Internships (No.)	NLN Accr.
Universitiy Hospitals, Columbus, Ohio	$49.19	219,360	191	48	+
University Hospitals, Ann Arbor, Mich.	46.41	219,770	337	44	+
Receiving Hospital, Detroit, Mich.	43.13	207,556	79	59	–
University of Minnesota Hospital, Minneapolis	41.59	119,602	222	40	+
Boston City Hospital, Mass.	40.33	409,876	241	74	+
University Hospital, Baltimore, Md.	36.55	182,113	160	30	+
Jackson Memorial, Miami, Fla.	36.11	209,009	221	82	+
Hurley Hospital, Flint, Mich.	36.07	23,505	38	25	+
Bronx Municipal, N. Y. C.	35.95	202,899	226	42	–
Indiana University, Indianapolis	35.06	72,519	....	35	–
University of Illinois Research & Education Hosp., Chicago	34.78	194,207	116	36	+
University of Kansas Medical Center, Kansas City	34.64	123,716	150	20	+
Harlem Hospital, N. Y. C.	33.74	261,216	52	49	+
Los Angeles Harbor General Hospital, Torrance, Calif.	32.38	127,773	82	38	–
Jersey City Hospital, N. J.	32.34	83,141	99	60	+
Orange County, Calif.	31.57	56,971	17	26	–
University Hospital & Hillman Clinics, Birmingham, Ala.	31.56	105,724	150	55	+
Meadowbrook Hospital, Hempstead, N. Y.	31.36	57,078	70	32	–
D. C. General, Washington, D. C.	30.91	156,057	125	62	–
Metropolitan Hospital, N. Y. C.	30.87	455,576	124	....	–
Los Angeles County, Calif.	30.73	618,601	252	160	+
Cincinnati General, Ohio	30.02	103,481	159	52	–
Bellevue Hospital Center, N. Y. C.	29.62	426,007	129	10	+
Milwaukee County, Wis.	29.10	132,203	105	36	+
City Hospital, Elmhurst, N. Y. C.	28.79	85,962	72	36	–
University of Oregon, Portland	28.75	110,770	111	30	+
Ancher, St. Paul, Minn.	28.50	85,566	22	26	+
Macon Hospital, Macon, Ga.	28.18	61,285	16	24	–
Grady Memorial, Atlanta, Ga.	27.96	432,254	126	52	+
Martland Medical Center, Newark, N. J.	27.91	36,934	26	30	–
University Hospitals, Madison, Wisc.	27.27	109,000	184	22	+
San Diego County, Calif.	27.04	34,321	34	20	–
Kings County Hospital, N. Y. C.	26.95	447,328	239	141	+
Edward J. Meyer, Buffalo, N. Y.	26.46	114,887	100	26	+
State University of Iowa, Iowa City	26.46	154,413	173	20	+
Queens Hospital Center, N. Y. C.	26.04	110,917	54	34	–
University of Texas, Galveston	25.44	130,330	166	37	+
Marion County General, Indianapolis, Ind.	25.31	150,983	78	40	–
Philadelphia General, Pa.	24.76	308,053	129	90	+
Medical College of Virginia, Richmond	24.71	90,647	134	60	–
St. Louis City Hospital, Mo.	24.65	147,378	129	70	+
Homer G. Phillips, St. Louis, Mo.	24.29	98,578	94	40	+
San Joaquin General, Stockton, Calif.	23.16	113,231	21	17	–
Baroness Erlanger, Chattanooga, Tenn.	23.03	39,389	47	14	–
City of Memphis Hospital, Tenn.	21.09	179,718	98	48	–
Kern County, Bakersfield, Calif.	20.61	110,820	35	12	–
Fresno County, Calif.	20.22	73,746	25	18	–
Sacramento County, Calif.	18.87	.....	16	26	–
Columbia Hospital, S. C.	18.49	78,080	12	15	–
Dallas County Hospital District, Texas	18.48	243,742	134	42	–
Charity, New Orleans, La.	17.94	567,380	329	126	+
Confederate Memorial, Shreveport, La.	14.81	151,224	75	31	–
Baltimore City Hospitals, Md.	12.30	80,311	75	31	–

NLN — Accredited schools of nursing.

Veterans Administration Hospitals

Outpatient Visits

Correlation of costs and outpatients was more difficult to establish in Veterans's Administration Hospitals because some hospitals have no outpatient departments. Despite this fact, 11 V.A. Hospitals which were in the top 20 bracket for cost were also in the top 20 in outpatient visits. As a general rule, however, V.A. outpatient visits were far below the numbers reported by the top hospitals in the other two groups.

Residencies

A high correlation was noted between cost and the number of residencies offered by V.A. Hospitals. Thirteen of the hospitals in the top 20 costwise were also among the top 20 in the number of residencies offered.

Since only two V.A. Hospitals also offered internships these cannot be said to contribute significantly to their cost per patient day. V.A. hospitals do not maintain accredited schools of nursing.

Table 3. Forty Veterans Administration Hospitals

VA Hospitals	Cost per Patient Day	Outpatient Visits	Residencies (No.)	Internships (No.)
Denver, Colo.	$33.13	.....*	73	....*
Dallas, Texas	29.77	33,449	56	12
VA Research, Chicago, Ill.	27.16	10,000	93	....
Albuquerque, N. Mex.	26.35	11,246	28	....
Minneapolis, Minn.	26.02	29,325	139	....
Bronx, N. Y.	25.74	54,694	143	....
Boston, Mass.	26.66	15,614	135	....
Salt Lake City, Utah	25.56	19,063	32	....
Cleveland, Ohio	25.51	.....	75	....
Hines, Ill.	25.23	13,744	175	....
Portland, Ore.	25.21	.....	52	....
Nashville, Tenn.	25.18	.....	24	....
Richmond, Va.	24.68	17,018	80	....
Memphis, Tenn.	23.98	.....	65	....
Kansas City, Mo.	23.82	5,010	30	....
Brooklyn, N. Y.	23.49	.....	88	....
Vancouver, Wash.	23.22	2,045	....	....
Oakland, Calif.	23.13	5,554	25	....
New York City, N. Y.	22.88	12,677	117	....
Albany, N. Y.	22.66	26,813	41	....
Indianapolis, Ind.	22.60	6,120	32	....
Houston, Texas	22.53	13,279	113	....
Dublin, Ga.	22.40	4,900	....	....
Dearborn, Mich.	22.21	16,575	39	....
West Haven, Conn.	22.10	.....	56	....
Jackson, Miss.	22.01	19,419	8	....
Los Angeles, Calif.	22.00	35,162	204	30
Bay Pines, Fla.	22.00	5,610	....	....
Milwaukee, Wisc.	21.98	12,385	65	....
East Orange, N. J.	21.93	.....	36	....
Long Beach, Calif.	21.77	59,273	80	....
Columbia, S. C.	21.42	.....	....	....
Pittsburgh, Pa.	21.39	.....	48	....
Cincinnati, Ohio	20.65	28,510	....	....
Martinsburg, W. Va.	20.56	.....	7	....
Buffalo, N. Y.	20.35	59,951	42	....
Temple, Texas	19.50	.....	....	....
Mt. Home, Tenn.	18.33	1,400	....	....
Wadsworth, Kan.	17.76	16,072	12	....
Augusta, Ga.	13.73	215	15	....

*None

a.c.h.a. activities

Regents Election

Nominations of candidates for positions on the governing body of the College, the Board of Regents, are being requested from the membership to fill vacancies being created in six regions.

Primary ballots have been sent to Fellows and Members of the professional society in Regions No. 3, 6, 9, 12, 13 and 16.

Four of the six Fellows currently serving as Regents in these regions are eligible for re-election. They are: Delbert L. Price, administrator, Children's Memorial Hospital, Chicago (Region 9); Boone Powell, administrator, Baylor University Medical Center, Dallas (Region 12); Roy R. Anderson, superintendent, Presbyterian Hospital, Denver (Region 13); and Donald R. Easton, M.D., superintendent, Royal Alexandra Hospital, Edmonton (Region 16).

Because they have completed two successive terms of service to the College as Regents, Clyde L. Sibley, administrator, Birmingham Baptist Hospital, Birmingham (Region 6) and Harold T. Prenzel, administrator, Montgomery Hospital, Norristown, Pa. (Region 3) are not qualified for re-election, according to the by-laws of the professional society.

Candidates for the Board of Regents must be Fellows in the College and practicing administrators or assistant administrators of approved hospitals in the region in which they are nominated for election.

Election judges of the College are Kenath Hartman, superintendent, Chicago Wesley Memorial Hospital, chairman, Martin H. Hough, administrator, Augustana Hospital, Chicago, and Charles M. Smith, administrator, Community Hospital, Geneva, Ill.

Preceptors Conference

The Midwestern Preceptors Conference, originally scheduled to be held in St. Louis in Mid-May, will be presented in Chicago on August 14-15.

Site of the conference will be the headquarters of the American Hospital Association on Lake Shore Drive.

The conference will be held concurrently with the college's 12th Chicago Advanced Institute for Hospital Administrators, scheduled for the AHA building in Chicago between August 14-18.

Preceptors Conferences are sponsored by the College for preceptors, course directors and administrators considering the introduction of residency training programs at their hospitals. There is no tuition fee for these conferences.

For more information on the Midwestern Preceptors Conference, or for registration applications, write directly to the College.

Regional Conference

A College-sponsored Regional Members Conference will be held at the Belmont-Plaza Hotel in New York between July 10-12 for the membership practicing in Region No. 2, the state of New York.

Peter B. Terenzio, executive vice-president of The Roosevelt Hospital in New York City is the Regent of the College in that state.

The three-day conference will feature guest speakers and informal group workshops.

Tuition for the Regional Members Conference is nominal: $15. Registration forms are available from the College.

Dr. Louis W. Norris, President of Albion College in Michigan, was the guest speaker at the College-sponsored Administrators' Luncheon held during the Tri-State Hospital Assembly in Chicago.

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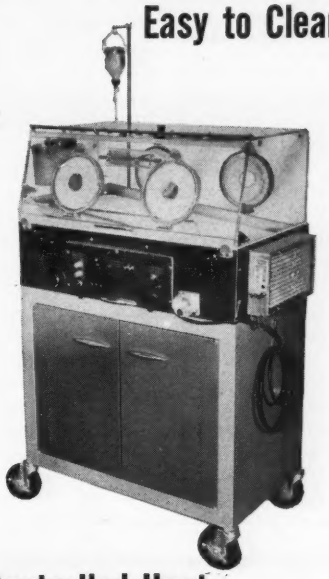

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Housekeeping Records

by Rosalie E. Cain

Executive Housekeeper
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■ If an executive housekeeper is to be successful and keep the cost of the housekeeping department at a minimum, there are many records which will be of assistance.

Central Linen Issues is helpful in more ways than one, as it is a current and perpetual inventory plus a way of keeping track of our linens. Each area sends in a mimeographed form once each week listing the linen needed for the forthcoming week. At the time the requisition is presented, their shelves could be completely empty. They are very seldom empty, because in an institution of this type, untidy patients are taken into consideration with the amount ordered for them usually higher than necessary.

Statistics of this department have also been helpful to other departments. For example, the laundry manager was asked to estimate the number of pounds he laundered each week. Not having a large enough scale, he had no way of knowing. Consulting our department, he found we had a record of the exact quantity of each item each week. By weighing one sheet, one bath towel, and other items, he was able to arrive at a fairly accurate figure.

Central Linen Discards. Prior to establishing Central Linen, each building had a par stock of linen. All items are marked with the name of the institution as well as the area to which it was issued. When an item wore out, the corner having the name and area were cut out and when 12 were accumulated for the same area, they were sent to the sewing room which then issued them one dozen of whatever the item may have been.

By checking our stores cards, we were able to determine how many dozen were issued over a certain period of time. Now, with Central Linen in effect, all discarding is done by the supervisor of the department. The stamped corners are not saved, but the supervisor keeps a record of how many of each item she discards each month. Knowing the number she discards each month, and the number that were previously issued for the same length of time, we have a good means of comparison.

In our own institution, pre-Central Linen, discards of sheets were 88-dozen for 9-months. Since having Central Linen, we have discarded 33-dozen in 9-months. Another item worthy of mention is hand towels. Ninety-four dozen were discarded pre-Central Linen, as compared to 21-dozen for the same length of time since having Central Linen. The reason for this is explained in the June, 1960 issue of HOSPITAL MANAGEMENT, page 120.

Record of Sewing Room Requisitions is felt to be very important as it gives a way of checking orders, as well as keeping control of the situation. Any cottage wanting something to be made in the sewing room fills out a mimeographed requisition stating the name of the article, size, material desired, and the quantity. This is sent to the business manager for approval, then to the executive housekeeper who also signs it, as well as records it in her book. For example, in the past it was customary to tie laundry in sheets. This is unfair to the sheets, as pulling the corners weakens the threads. We now insist that laundry bags be used. (This could be one reason why fewer sheets are discarded.)

One cottage continued using sheets for laundry bags long after the others had changed over. Their excuse was "We don't have any laundry bags." By referring to the records, it was noted they had issued three orders for three-dozen each in three-months' time. Yet, they never seemed to have any. It took a special tour of the building to find them. A new aide, not realizing their importance, put them in a storage room in the basement.

Lather • Fragrance • Safety
Premium antiseptic liquid soap
Balmaseptic
For washroom and shower
Contains Hexachlorophene
Clear, brilliant Balmaseptic rubs up quickly into handfuls of fragrant lather. Cleanses energetically, yet does not irritate the skin — does not chap. Regular use keeps the hands surgically clean: the HEXachlorophene puts the HEX on bacteria. Balmaseptic dispenses neatly — stores perfectly: does not turn cloudy or rancid, regardless of climate.
Exceeds forthcoming U.S.P. Specifications for Hexachlorophene liquid soap
For free sanitary survey of your premises ask your Dolge service man
Dependable
DOLGE
WESTPORT, CONNECTICUT

For more information, use yellow postcard inside back cover.

They had been ordered. They had been made. They had been delivered. *BUT*, they had not been used.

Record of Budget Requests is an invaluable timesaver at budget time. A page is ruled, using the following captions: date, item, quantity requested, actually received, from whom ordered and the price. When ordering an item it is not necessary to check back through several books of requisitions to obtain the last price—it is right in the book in the housekeeper's desk.

Record of Keys. If the executive housekeeper has control of the keys it can be simplified or complicated, depending on how much one is interested in detail. We keep two records of keys. One lists the keys as to area and has a cross file listing them numerically. The other is a page listing the keys issued to employees who must have their own set. This gives the number of the key and the door which it will open, and is signed by the employee.

Weekly Sewing Report. Each seamstress fills in her own page. This is of great help when making up the monthly report which goes to the general office. There again, the Budget Request Record comes into use in giving the price per yard of items. The salary of each seamstress is figured on an hourly basis, thereby making it easy to determine the labor cost. Cost accounting sounds complicated but it can be made very simple. A certain small percentage is added to the material cost in figuring the cost of items made. By adding the material cost and the labor cost, we arrive at the cost of the finished product.

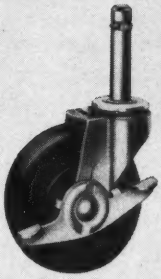
Sewing Room Report is made out in triplicate each week. The warehouse picks up the finished sewing on Friday, signs the report, and machine stamps the articles for the cottage for which they are intended. The warehouse accepts the original copy, the sewing room keeps the second copy and the third is sent to the executive housekeeper for her records. If there is a difference in final figures for the monthly report, a cross check can be made with this page and with the one seamstresses make out.

A *Diary Record* is kept of notes taken when making rounds of all areas. If a curtain needs repair, a screen is torn or a room needs painting, trouble slips are issued for this work and if it is not completed within a reasonable length of time, a follow-up is made to see why not. ■

"Bassicks" to help keep

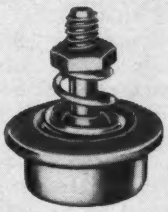
costs down, service up!

Bassick casters and floor protectors can help cut equipment maintenance and operating costs, and save floors. Their non-marking wheels keep floors neater, cleaner, with less work. You'll save on caster replacements—and the cost of replacement, often more than the price of the caster itself.

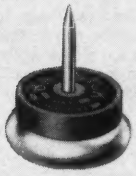


Series "69"...4" and 5" sizes for both regular and multiple position hospital beds. Inexpensive "shimmy dampener" available for utmost in low noise and firm support. Easy swiveling Series "69's" also do an outstanding job on invalid walkers, utility carts, and X-ray machines. Other sizes down to 1⅝".

Conductive casters . . . provide dissipation of static electric charges from equipment. Available in soft-tread Bassick "Baco" wheels in almost all Series "69" caster styles, they meet Interim Federal Specification FF-C-77 requirements on electrically conductive casters. 1¾", 2", 3", 4", and 5" wheel diameters.



New "No-Roc" glides . . . something new for cafeteria, dining room or equipment tables. Bassick "No-Roc" table glides quickly and **automatically** adjust themselves for minor floor irregularities and end wobbly tables, forever. Designed for tables having four or more contact points and weighing 30 pounds or more.



New Nylon glides . . . for office, reception room, or patient's furniture, new Bassick nylon-base glides can't rust, can't corrode, can't stain floor coverings. Broad, resilient, nylon base provides greater floor protection, too, even for modern cork or asphalt tile.

Learn more about Bassick casters and glides. Write for information. 1.31

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I.V. Stand
you can't
knock down

. . . and the POLECAT

is the lightest and least expensive on the market!

After seven years of hard service in over 2000 hospitals, POLECAT has proved itself beyond a doubt. No more risk of injury to patients. No more tripping over extended legs. No more pulling and hauling to get a heavy stand into the room. Just spring a POLECAT into position *(with one hand!)* between floor and ceiling and *right at the point of insertion* so that tubing isn't in the nurse's way. They're for ceilings up to 10'6" and they cost only **$16.75**

POLECAT takes no more space than a postage stamp, weighs only two pounds!

Hooks are easy to tighten . . . but bottles can't fall even if hooks aren't tightened at all!

A dozen POLECATS can be stored in a THIRD of the space one regular stand requires.

Patent applied for.

Ask your supplier, or write for brochure to:

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Dept. HM-7, Lyme, Connecticut

ENGINEERING - MAINTENANCE

by Daniel M. Roop, P.E.

Do You Know —

What percentage of your entire capital investment is in mechanical, electrical and plumbing facilities?

What percentage of your total departmental operating budget is being spent for water, fuel and electricity?

What percentage of your total general costs of overhead are spent on utilities?

What is your percentage relationship between labor costs and expenditures for materials and supplies for day-to-day operations and maintenance?

Engineering Management

The Physical Plant
Personnel
Operations and Maintenance
Fiscal Finances of Physical Plant Services

■ THE DAYS of the do-it-yourself fads have rapidly diminished. In most areas, where the layman used to consider himself an expert in building maintenance and repairs, we find today complicated equipment and systems that are beyond the capabilities of most personnel available in our service areas.

Hospital engineering and technological developments in structure and equipment have assumed completely different aspects and created problems for the administrator far beyond those previously encountered.

The area of responsibility covered by the engineer and his staff includes the entire capital investment of the hospital of which 55 to 65 percent is in the mechanical, electrical and plumbing facilities and 20 to 25 percent is in Groups I and II equipment. In addition he is concerned with the structure and architectural treatment.

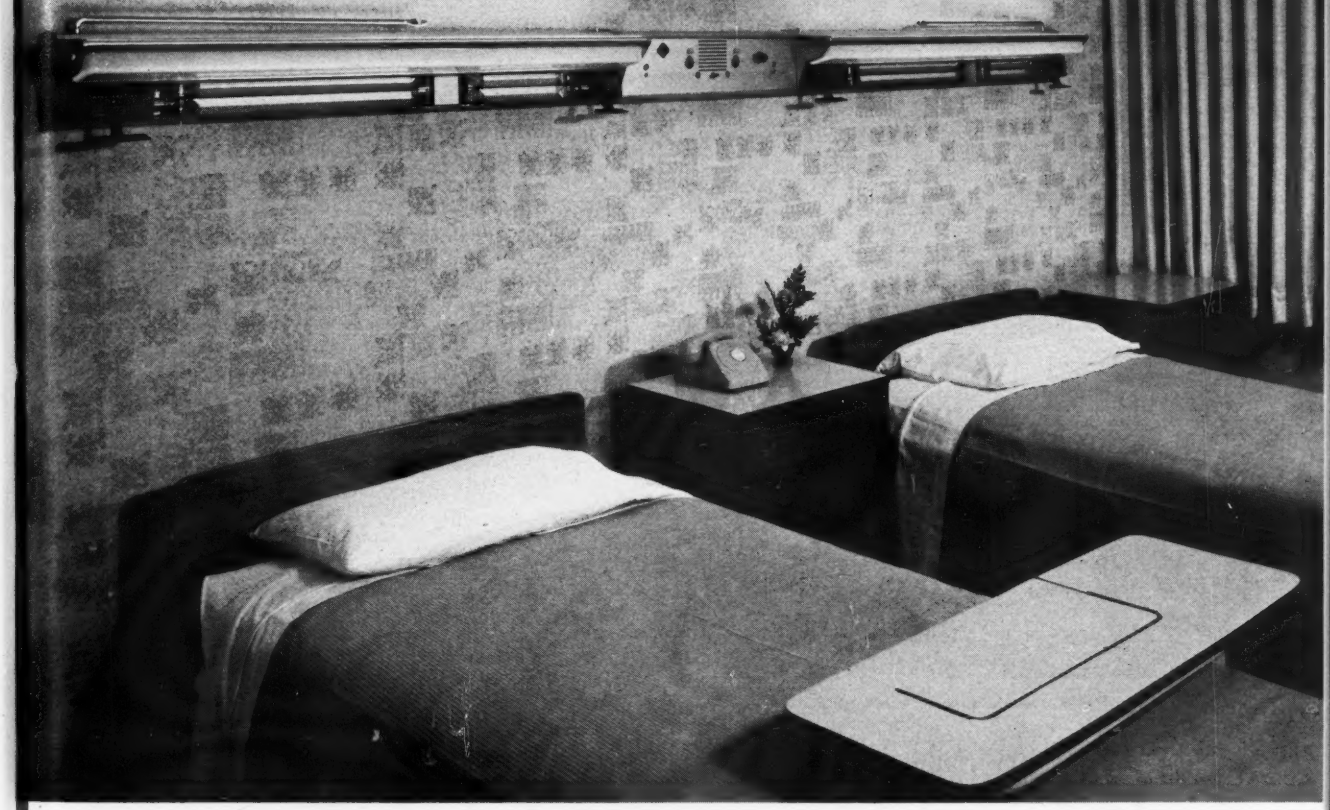
The Physical Plant

The engineer must have knowledge of the entire physical plant and properties, including all equipment. He must be cognizant of the "state of conditions" of the buildings and equipment and of their efficiency and usefulness for the task for which they were designed. The study, evaluation and review of methods and procedures are important as they are related to the physical surroundings and personnel assigned to these areas. With the facts at hand, the formulation of procedures and recommendations for improved methods can help secure better services at lower cost.

In order to provide a high standard of service, an inspection of the electrical, mechanical and plumbing facilities is necessary to determine whether they are adequate and sufficient in number for the demands placed upon them, and to provide a continuing awareness of their safety. Good fire prevention techniques and safety procedures can help you lower your insurance costs.

Do you have a completely reliable plan for disaster needs such as standby power, emergency sewage and waste disposal, adequate emergency water supplies, emergency

CENTRON-10 CONSOLIDATES UP TO TEN LIGHTING AND PATIENT SERVICES INTO ONE SYSTEM

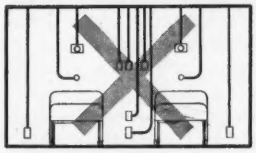


GLARE-FREE GENERAL ILLUMINATION • SHIELDED READING LAMP • HEAT-ABSORBING, COLOR-CORRECTED EXAMINATION LAMP • NIGHT LIGHT • TAKES VARIOUS AUDIO-VISUAL NURSE CALL SYSTEMS • OXYGEN AND VACUUM OUTLETS • TELEPHONE, TELEVISION, RADIO AND CONVENIENCE OUTLETS • INTRA-VENOUS APPARATUS SUPPORT

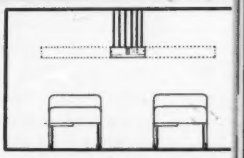
CENTRON-10 brings functional beauty and patient service integration to the hospital bedroom which is particularly appealing to architects, consultants and administrators. The system provides lighting for every seeing task. Softly diffused indirect lighting is pleasant and glare-free. The reading and examination lamps swivel on extendable arms for easy positioning. Centron-10 is adaptable to various nurse-call and oxygen/vacuum systems. It can be installed on any type of wall in new construction or in remodeled interiors. Compact styling and rounded contours help reduce housekeeping costs.

EXAMINATION LAMP, integral with Centron-10, is most convenient.

READING LAMP shielded fo minimum disturbance to othe patients.



OLD WAY—Up to 11 separately installed outlets clutter each side of the wall.



CENTRON-10 WAY—All servic lines consolidated and con cealed for clean appearance.

THERE IS NO OTHER SYSTEM LIKE IT!

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How can you have an orderly maintenance program with this kind of maintenance shop?

fuel for cooking and heating? These all require your engineering management knowledge and skills.

Personnel

The physical surroundings often create inefficiencies and employee dissatisfactions. A study and review of the qualifications of personnel in various job classifications may in turn show that these people have been misplaced or misassigned and that they do not have the abilities to perform the task for which they were hired. Perhaps they are expected to perform tasks that are completely foreign to them. This is true of a high percentage of service department employees in many rural and intermediate areas where hospital facilities have recently been constructed. Whether you have one, two, three or more men in the maintenance or custodial services of the hospital, internal department organization is necessary to assure proper coordination and functioning of the patient care program.

Overstaffing is costly — so is understaffing. Do not be fooled by the recommendations that may be in some textbook about the "right" number of employees. The factors of size, adjunct facilities, age, mechanical plant and geographical location are all important considerations in determining the correct number of personnel. The use of contractural services will also weigh heavily in such decisions.

No matter how small the job is, job descriptions are necessary. This is especially important in the areas of plant operation and maintenance where the employee may be required to use many different skills. There is a crossing of the trades and, even though one man does all the work, engineering management must make sure that he is utilizing his time to the utmost and that he is performing all of the necessary work. You might be surprised if you knew what your employees are doing and equally surprised by what they are *not* doing.

The establishment and continued review of wage standards for your employees in all classifications is good engineering management practice. This may be accomplished by an individual hospital, local hospital council or state hospital association. It is more meaningful, however, if it is done on a local or regional council basis.

One skilled well-paid employee who is satisfied and conscientious is worth two or three employees receiving half the pay and wasting three times the manhours.

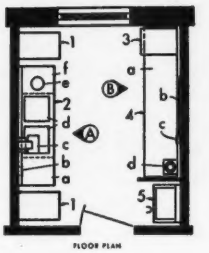
Operations and Maintenance

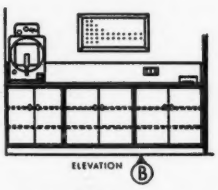
First differentiate between corrective maintenance and preventive maintenance. Maintenance itself is the *controlled rate* of deterioration. The heart of the hospital plant operations is the hospital maintenance shop. This is where maintenance begins — or does it? If your shop is like the one pictured (*figure 1*) you cannot have an orderly maintenance program of any kind. A sound maintenance program should

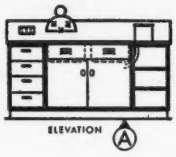
Please turns to page 62

HERE!-------

a low cost practical technic for the small INFANT-FORMULA ROOM







The Amsco electric heat Model 832 Formula Sterilizer enables hospitals with one to eight bassinets to carry out advanced techniques formerly possible only with large capacity equipment costing much more. Its capacity of 32 four or eight ounce bottles is ample to serve eight bassinets, using two cycles per day. The Model 832 requires minimum attention from the operator because complete cycling is automatic and forgetproof according to the time, temperature and exhaust settings selected.

Permits a Modern Formula Room in the minimum area.

With the model 832 as the basic unit, Amsco has developed special techniques and complete equipment suitable to Formula Room planning for the small nursery. Layout and equipment are fully in harmony with the most advanced standards of infant formula processing and work simplification . . . yet the space requirements and all-inclusive costs are extremely modest.

For complete information on the small Infant Formula Room, write for bulletin SC-319. (Hospitals with larger nurseries should request brochure SC-320R.)

World's largest Designer and Manufacturer of Surgical Sterilizers, Tables, Lights and related equipment.

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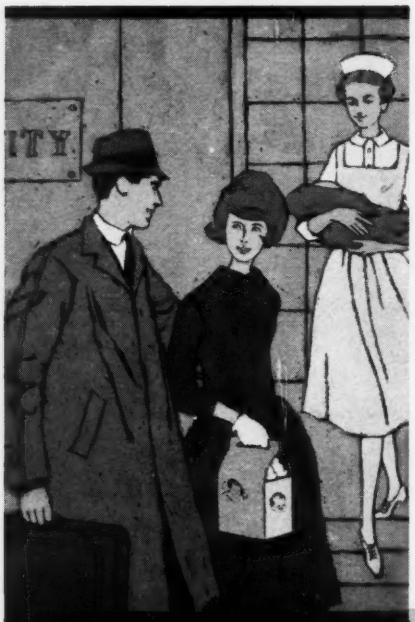
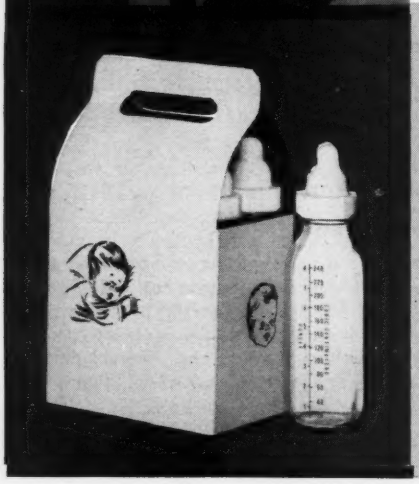
For more information, use yellow postcard inside back cover.

You earn more than good will... with Davol's Formula Service Plan





AT NO COST TO YOU—you can send your mothers home with a 24-hour supply of formula and a complete set of nursers, ready to warm for baby. And the plan is *more* than self-liquidating for the Hospital. It is simple and easily administered—

1. **Hospital buys,** at a special price, six 8 oz. Feed-Rite Nursers with famous Feed-Rite Nipples. Davol easy-to-assemble "Handy Racks" are also included.
2. **Hospital offers** each new mother, before discharge, a 24-hour supply of formula. It is given to her in a Davol Handy Rack with 6 Feed-Rite Nursers, for the regular retail price of the Nursers alone.
3. **Davol furnishes** attractive Order Forms for mothers to fill out, which explains the Plan you have chosen. There is no reference to Davol in these forms.

CHOOSE ONE OR MORE OF THESE 5 TAKE-HOME PLANS

All prices are for 6 complete nurser units plus Handy Rack.

DAVOL Feed-Rite Glass Nursers	Hospital Price	Suggested Price to Mothers
PLAN 174P "Color Scale" Duraglas Nurser, with Nipple Cover	$1.45	$2.35
PLAN 154P "Color Scale" Duraglas Nurser with Seal	$1.25	$2.10
ECONOMY PLAN 354P Plain Glass Nurser, with Seal	$ .95	$1.50
DAVOL Feed-Rite Plastic Nursers		
PLAN 274P Feed-Rite Plastic Nurser, with Nipple Cover	$1.65	$2.65
PLAN 254P Feed-Rite Plastic Nurser, with Seal	$1.45	$2.35

ORDER FROM YOUR HOSPITAL DEALER, OR FOR FURTHER INFORMATION, WRITE TO: DAVOL® RUBBER COMPANY
PROVIDENCE 2, RHODE ISLAND

NAHCSP NEWSLETTER

Official newsletter of the National Association of Hospital Central Service Personnel
60 East Scott Street, Chicago 10, Illinois, Elizabeth J. Hanna, Executive Secretary

Convention Highlights

The second annual convention of the NAHCSP was held May 4-5, 1961 at the Morrison Hotel in Chicago. The morning of the first day, May 4, was strictly a business meeting in which each of the officers presented reports to the House. (The president's report is presented elsewhere on these pages).

Some of the local groups informed the House of some of the activities they had undertaken during the past year. The outgoing president informed the group that the following motions were presented and agreed upon at the Board of Trustees meeting which was held immediately preceding the House of Delegates meeting:

That two delegates at large be appointed to the board of trustees because of the expanding membership of the association.

and

That a management seminar be held early in 1962 to accommodate the numerous requests from the membership for such a seminar.

These two resolutions were ratified by the membership.

The induction of new officers then took place, as follows:

President-Elect: Esther Abbott, Supervisor of Central Service, Chicago Wesley Memorial Hospital, Chicago

Delegate at Large: L. Mabel Hartley, C.S. Supervisor, V.A. Hospital, Erie, Pa. Harriett Melland, C.S. and Purchasing Supervisor at Grace Hospital, Hutchinson, Kansas

Treasurer: Edith Pauline Johnson (This is a three-year office with term expiring in 1962), C.S. Supervisor, Augustana Hospital, Chicago.

The outgoing president, Eva Buckingham, then presented the president for 1961-1962, Julia Findlay, C.S. Supervisor, Mt. St. Mary's Hospital, Niagara Falls, N. Y. Said President Findlay:

"In accepting this great honor which you have bestowed upon me, I realize what a difficult task I am undertaking in following so great a president as Eva Buckingham. If I can do only half as well as she has done, I will consider my term of office to have been a great success.

"With all the groundwork which has already been laid down by the past officers my task will be to advance the activities in which we are already engaged and, if possible, to expand them.

.."Our immediate task is to plan the institute for this Fall and to explore the possibilities of holding another institute early in 1962 so that we might have both a Spring and a Fall institute to serve our members better.

"It will also be one of my tasks to help to develop the central service manual and to work closely with the research committee.

"With the help of the board of trustees and officers of the Association, I look forward to a great year of developing the Association."

At this point, the meeting of the House of Delegates was adjourned and all attended a luncheon.

Please turn to page 55

Our Officers

Julia Findlay, President
Niagara Falls, New York
President (1961-1962)

Esther Abbott
Chicago, Illinois
President-elect (1962-1963)

Edith Pauline Johnson
Chicago, Illinois
Treasurer

Please turn to page 54

Report of the President

by Eva Buckingham

I look back with a great deal of satisfaction upon my term of office and the accomplishments of the Association. Two years ago when I took over the presidency of the Association, we had only a handful of members, no money and everybody trying to help out in running the Association from their little office in the central service department (those who had them) or from their own home. Many had the idea that this was a Chicago Association mainly because the only people available for quick communication were from Chicago. We have come a long way since then. We have heard our National Secretary report that we have had a steady increase in membership.

Our accomplishments include an institute which has been held two years in a row and a third is being planned for this year. These institutes have received a very enthusiastic response from our members, so much so that pressure has been put on us to run two institutes a year instead of one. We have tried to have the program of the institutes on a practical level and last year we included some workshops on problems in c. s. I am sure all of you read avidly the reports of these workshops in our newsletter which is written on the pink pages of HOSPITAL MANAGEMENT magazine.

Manual

This is not the extent of our educational activities; this is only the beginning. During the past year, we have been accumulating quantities of material which we hope to put together and publish as a procedure manual for central service. It is not an easy job to put this document together as we have found out. As long as we have to use volunteers, we are limited by the time that they have available to devote to this. We are now exploring the possibility of hiring a professional writer who would be paid by a research grant. The research committee is presently exploring this.

In the field of education, we have had numerous demands from people who want to know where they can take a course in central service. During the past year Arno Michlowitz, our vice president from New Jersey, and the Administrator of Clara Maass Memorial Hospital worked out a curriculum for training c. s. personnel which was approved by the board and is now being offered by the hospital as the first training program in c. s.

Eventually, the Association may become an approving body for such programs.

During my term of office I have seen the Association develop its own pin, acquire its own headquarters, its own executive secretary and its own telephone listing. We are a very young organization. EVERYTHING WE HAVE ACCOMPLISHED HAS BEEN DONE BY THE INITIATIVE OF OUR OWN MEMBERS AND WE ARE BEHOLDEN TO NO ONE OUTSIDE OUR OWN ORGANIZATION.

As a result of our independence and our refusal to accept gifts from commercial groups, our growth has not been as quick, perhaps, as it might have been but we feel that it will be more stable and more permanent. For there is always pride of accomplishment in the knowledge that you have successfully done a job through your own efforts.

In closing I would like to thank all of our officers and members who supported me so loyally during my term of office. As I hand over the reins of the presidency to my successor, I want to assure everyone of my continued interest and I expect to work just as hard now as chairman of the membership committee in support of our new president as the members worked in support of me.

Our Officers

Continued from page 53

Harriet Melland
Hutchinson, Kansas
Delegate at Large

Mabel Hartley
Erie, Pennsylvania
Delegate at Large

Convention Highlights

The Thursday afternoon session, May 4, began at 2:00 p.m. with Mr. James Herman, Director of Division of Administration Services at Presbyterian-St. Luke's Hospital discussing PLANNING FOR DISASTER, then Mr. Addison Young, Inhalation Therapist at Oak Park Hospital presented, HOW TO SET UP AN INHALATION THERAPY DEPARTMENT and finally, Mrs. D. Ann Sparmacher, executive secretary, Chicago Council on Community Nursing, gave us her thoughts on COMMUNICATION.

The Friday, May 5, session was a workshop on

How to Compute Costs of Trays
Group Leader: Eva Buckingham

Evaluating Products
Group Leader: Harriett Melland

Breakage and Loss
Group Leader: Blanche Jorgenson

Qualifications for Aids
Group Leader: Brother Valentine

The report of the workshops ended the two-day convention. ▣

Mr. Addison Young checks with Mr. Mayfield of Puritan Compressed Gas Corporation for last minute instructions.

Dollie Lemke and Alice Witham, both of Ohio, checking over giveaway materials.

Doctor Letourneau presented the Legal Aspects of C.S. during the luncheon.

Speaker James Herman was so popular that he answered questions all the way down the aisle.

Brother Valentine of Alexian Brothers Hospital, St. Louis, was a new acquaintance to our group.

Sister Elizabeth Marie of Firmin Desloge Hospital in St. Louis participated actively in the workshop.

Blanche Jorgenson (left) and Alvira Rayfield, both of Chicago, comparing notes on their departments.

Mrs. D. Ann Sparmacher is always a most welcome addition to our meetings.

Mid-West Hospital Association

Dr. Louis Block, president, Academy of Hospital Counselors and Betty Hanna, executive secretary of NAHCSP exchange notes on associations.

Edith Pauline Johnson, NAHCSP treasurer enjoyed meeting Mrs. Ruth Maring of the VA Hospital in Kansas City.

Gertrude Beaver and Phoebe Ring are NAHCSP members from Omaha, Nebraska.

This has been a busy month indeed. Representatives of NAHCSP attended the central service section of the Mid-West Hospital Association in Kansas City, Mo., April 26, 27 and 28. The meetings were well attended and everyone felt that they had gained a great deal of knowledge through their attendance. Mrs. Harriett Melland, NAHCSP delegate-at-large was the program coordinator for the Mid-West Central Service meetings.

Esther Abbott and Edith Johnson spent a great deal of time visiting the various booths and finding out about the newest advances for central service departments.

NATIONAL ASSOCIATION OF HOSPITAL PURCHASING AGENTS

Mrs. Orpha Daly Mohr
Secretary-Treasurer
National Association of Hospital Purchasing Agents
c/o Oak Park Hospital
525 Wisconsin Avenue
Oak Park, Illinois

Purchasing Under Budget Law

by R. M. Browne
Procurement Officer
California Medical Facility
Vacaville, California

Reference to Webster is hardly necessary for any of us to know what the word budget means. For the scope of this article it means a financial estimate or a plan of expenses in government. It applies to hospital purchasing as well as to other government entities. And Procurement Officers under budget control find that once set, the budget amount is quite as inflexible as any of our many traffic laws.

To properly function under such control our *modus operandi* might well be classified into four major problem areas. Each Procurement Officer knows exactly what the word problem means: a perplexing situation proposed for solution. However, a solution is also implied and expected of every Purchasing Agent—in *each* of these following four areas.

Forecasting

Every P.A. should be prepared to assist in predicting financial needs many months before the actual need for materials arise. A budget normally covers the period of one year; it takes an additional three to six months to obtain approval—to process our needs on paper. So, it becomes a requirement to forecast as much as 18 months in advance. Hospitals operating on the basis of a fluctuating patient-day are guided by the best occupancy prediction available. Hospitals operating at capacity, or near capacity, have somewhat less fluctuation in their gamble. However, both such institutions *must* project their needs by past experience.

Past purchasing experience in any hospital is invaluable to enable proper forecasting of future needs. Yet, someone has said the knowledge of the P.A. must include usage-time estimates, strike influences, and a knowledge of the weather. This is facetious. He is not expected to outguess the market, but he must be prepared to assist any department head in planning toward the months ahead. His knowledge of usages and cost should filter down into every facet of hospital operations. Sound planning and firm knowledge under foot are the basic keys to obtaining those purchase funds. If pressing detail curtails this area of his service, the P.A. is underperforming potential and expected duties. None of the managerial staff are *better* equipped to predict.

The word budget also means a bag with its contents. It takes departmental collaboration, staff conferences, *and* the above mentioned knowledge to intelligently prepare financial needs—the amount that should be put into the bag. We have learned that this is a sum requiring justification: an impregnable sum to withstand attack. Again, a major issue in the success or failure of this plea is the proper assumption of a forecasting responsibility by the P.A.

In most cases when the available sum is set it is divided into two categories: operating expense and capital outlay. No one among us in a professional capacity would accept any capital outlay figure without first a plan or a blueprint of construction. Knowledge and experience must be the blueprint of operations expense. It is naive to say that material markets are not static, or to complain that quality and prices change. Our area of service, and our strength, should be our knowledge of past markets, of prices as they are, and of obvious future trends. Anything short of this can weaken our individual position as well as the budget sum we plan to use.

Purchasing

On cursory glance *this* appears to be the area of our greatest service—the reason for being a P.A. It is assumed that after conferences, collaboration, and concessions, the budget is divided finally into the departments of hospital usage. Purchasing is also the basis for eight of the ten points included in the *NAHPA Code of Ethics*. Up to this point the P.A. has been a vital influence in negotiations between each of the departments for the equitable distribution of prospective needs.

Yet, when this division is set it also becomes a part of budget law. It stands as binding on each depart-

ment as the total bag is binding on the top management echelon. The responsibility of the P.A. truly begins when each department head begins dipping into the sack. It is like the first dip into a full bag of candy. The initial try always produces a larger handful, in spite of continued request for evenly divided quarterly orders. Beginning purchases include requests for all the items that were stretched over the dearth of money—dry last months of the previous budget year. Usually, though all these items are seriously needed, the order still may include a tendency to stockpile. I could easily tax hospital storage space to the bulging limit.

It is the responsibility of every P.A. to scan critically the unit consumption of all the merchandise he purchases. Our greatest need for such scrutiny comes at the heaviest detail portion of the year: during the *initial* quarterly department purchase requests. It is a continuing challenge to maintain stocks at levels commensurate with normal use. The challenge also becomes one of spreading the bag evenly over the 12 months. This becomes departmentally varied to the same degree that department heads are variable human beings. There are always some among us who overdraw personal bank accounts on occasion. The budget is no different.

None of the above relieves our responsibility of searching for new and improved products. In a recent case a department kept repeating a specific order for Royal Ortho Film for developing. Instead of getting the film, receipt delays developed, until finally a brave salesman exaggerated: "You can expect delays. It's made up special. That item went out with the Indian Wars."

Perhaps we cannot know everything. But every P.A. should make his rounds through the institution frequently; he should be an active part of every standardization and new-product program; he should know which department heads are doing the better job with the merchandise bought.

Ours is a State institution required to purchase by bid. Most service contracts are iron-clad. Much of the material is competitive —sometimes as to price alone. All material must bear exact specifications. Any slight deviation in this practice and retribution, although delayed, is sure to come. The supplier is forced to call for some missing information. Now he asks questions that take too much time; he

You realize, of course, this will remove you from my prospect list.

ships an item that closely compares with erroneous specifications we made; he ships all of an ordered item when we failed to request: 'delivery as requested'. Every vendor knows that, unless ordered otherwise, a full three-month supply is open to ship under quarterly bids. Warehouse-spacewise, *this* institution cannot afford such mistakes.

Every purchase request should be in writing. Suppose a department head phones an order that the P.A. puts into a formal request. Mixed into conversation about last evenings event for example, the order is heard as XYZ. Suppose it is misunderstood. Months later, when YZ comes in, no one knows at this late date who misstated the original description.

The Procurement Officer for a 2200-bed institution like this believes every day produces emergency orders. The ideal situation is for every department head to anticipate completely his needs for each succeeding quarter. Unfortunately that never happens, but keep all breaks in routine to a minimum. The extra time required costs money.

Personnel turnover: We must mention the problem of turnover of personnel. Turnover occasionally filters up to the department-head level. Human beings are variable; their likes and dislikes are divergent. We function toward a goal many months ahead. When previously ordered goods arrive the successor may innocently remark: "Why did you order this material?" Every P.A. should have the answer. He should be aware of varied source of items; he should at least be conversant with all departmental operations in his hospital; he should know the use and purpose of every item he purchases.

We are not subject to a dollar inventory control figure as found monthly on an industrial Balance Sheet. Often the best we can offer is unit control by common sense and diligent alertness. We must persuade department heads to order their needs in such a conservative manner that the budget year does not find him with an empty bag—in an emergency.

Recording

This particular area operates under office law: make no purchase commitment without an encumbrance entry—without reducing the available budget sum. But this objective is courted only after performing tremendous detail work. We must adjust each entered initial estimate to the final amount as billed. This is routine. Between estimate and final fact we have the accepted bid, the changes in price and description, the receipt or cancellation of a host of items. Although we keep current a 20-foot shelf of catalogues and pamphlets to aid selection, this varied detail is a continuing task.

However, this is the one logical means for *any* buyer to make contract arrangements attractive to each and every supplier. Knowledge and accuracy produce this objective automatically. Any large institution can readily succeed or stumble in direct proportion to amiable service from its suppliers. Make every sales interview inquisitive and brief, but make it business-like and courteous. Who knows, you may have to place that emergency order with *him* some day. Someday, human frailty being what it is, you may make the one error that needs his help to correct.

Here is a specific instance that comes to mind. An intended order for 1,000 pounds of Cabbage went out as 1,000 pounds of Brussels Sprouts. Fortunately P.A. and department head were both lucky. Brussels Sprouts were out of season.

Unit control under budget law is like the governor attached to a thirsty carburetor. When the money-dearth danger is approached at the end of the budget year all prior effort is better than driver's safety belt. Our goal is proper pricing, proper description, and the ordering of proper unit amounts. The warehouse is accountable for every shipment received. Special housekeeping and stationery supplies should

be distributed properly to every department according to need and use. All of this is a meticulous task. In recording, it behooves us to avoid as many errors as we can.

Fraternizing

This is a part of any treatise on professional practice. It may readily interpret the third point of our *NAHPA Code of Ethics: receptive to competent counsel from colleagues; guided by such counsel without impairing the dignity and responsibility of office.* Here the key meaning is service, and surely an objective that is accomplished by friendly communications alone. The duty of the P.A. is for close coordination between himself and each department in the hospital; his objective is to implement the desires of each department in an advisory capacity.

Essentially it is the duty of every P.A. to know the hospital needs. But under budget law only by visiting each department may he exert unit control to avoid careless stockpiling. This takes time and is not simple. The P.A. must not lose sight of diplomacy in this area. He must not tactlessly confine energy to flaunting human estimate errors. Such a person quickly impares the dignity and responsibility of his own office. Communication breaks down; service is no longer possible regardless of honest intent. It is a recognized principle in all human relations that success of any well-intended service aim comes only after friendly contact is maintained.

The P.A. should not defeat all his effort spent on burdensome detail. The one sure way for such defeat is to wait until an emergency arises close to the end of the budget year before he advises the department head there is no money left. This is how *not* to win friends and influence your colleagues. And this is the parting point: lack of effective fraternizing is the very antithesis of purchasing under budget law. ■

New Officers of Affiliated Associations

Toronto

■ THE TORONTO REGIONAL ASSOCIATION of Hospital Purchasing Agents met on April 27, 1961 at Cassidy's Limited in Toronto.

Plans were laid for meetings during the coming year and the By-Laws amended with respect to dues in order to facilitate payment of dues to the National Association.

Following the slate of officers presented by the Nominating Committee the following Officers were elected by acclamation.

President
Miss Mary Finger
Assistant Administrator
Women's College Hospital
Toronto

National Director
Mr. George Miller
Director of Purchasing
National Sanitarium Association
Toronto

Vice President
Mr. Andre Schabracq
Purchasing Director
New Mt. Sinai Hospital
Toronto

The National sends congratulations and good wishes for the coming year. Also, says, Thank You to a fine group of Officers who have led your Local group since its inception.

Milwaukee

■ THE MILWAUKEE ASSOCIATION met on March 29 at St. Lukes Hospital. The Association invited National Secretary-Treasurer Orpha Mohr to meet with them and report on the activities of the National Association. Since Mrs. Mohr met with them on their first official meeting she was honored to be in attendance as their new officers took over.

President
Mr. Thomas J. Burke
Supply Officer
Veterans Administration Hospital
Wood, Wis.

National Director
Mr. Joseph Labinski
Purchasing Director
St. Francis Hospital
Milwaukee, Wis.

Vice President
Mr. Art Villmer
Veterans Administration Hospital
Wood, Wis.

Secretary-Treasurer
Mrs. Charlotte Spines
Doctors Hospital
Milwaukee, Wis.

Chicago

■ THE CHICAGO AREA ASSOCIATION met on May 18, 1961 at the American Hospital Association Building for lunch and a Round Table Discussion meeting. Officers elected for the coming year are as follows:

President
Mr. George Sprague
Assistant Administrator
Silver Cross Hospital
Joliet, Ill.

National Director
Mr. Edward Blazyk
Assistant Administrator
St. Francis Hospital
Evanston, Ill.

1st Vice President
Miss Edith Kruse
Purchasing Director
Passavant Memorial Hospital
Chicago, Ill.

2nd Vice President
Miss Mary Ann Gilster
Purchasing Director
West Suburban Hospital
Oak Park, Ill.

Secretary-Treasurer
Mr. Walter Furtner
Purchasing Agent
Little Company of Mary Hospital
Evergreen Park, Ill.

Did you know?

✔Past President Joseph Heeb was recently appointed administrator of St. Joseph's Hospital, Wichita, Kan. He also chaired an excellent three-day purchasing meeting at the Midwest Hospital Conference in Kansas City.

✔National Secretary — Treasurer Orpha Mohr addressed the opening session of the Midwest Hospital Conference and several other members participated in the program.

✔President-Elect R.A. Clelland, business administrator at Arizona State Hospital, Phoenix, Ariz., was guest speaker at the Upper Midwest Hospital meeting in Minneapolis. Rod is also the incoming president of the Arizona State Association of the National Purchasing Agents Association.

✔Martin Mix, vice president district No. 4, presided at several of the purchasing meetings at the Tri-State Hospital Assembly held recently in Chicago. ■

The $64?

Permission to reprint this Column each month for the National Association of Hospital Purchasing Agents was granted by Mr. Frank M. Rhatigan, secretary of the American Surgical Trade Association.

QUESTION: What is the present address of the R. P. Corporation, makers of the Drymaster Film Dryer? Former address—4005 Washington Blvd., St. Louis, Mo.

ANSWER: Now at 1831 Franklin St., St. Louis, Mo.

QUESTION: What is the source of supply of Neiberg and Chang Stomach Brush with Cystometric standard?
ANSWER: Cochrane Physician's Supplies, Inc., 521 E. 72nd St., New York 21, N. Y.

QUESTION: Do you have information on a disposable, self-filling, self-measuring capillary pipette for blood count which was recently developed by Esso Research Laboratories? Do you have their address?
ANSWER: Becton, Dickinson and Company, Rutherford, N J. will be the sole manufacturer and distributor of this product. It will soon be released to the trade.

QUESTION: Advise us who makes the Hemo-Vac Suction Outfit with disposable catheter, for drainage through a tube, with collection bag on the outside of the body.
ANSWER: Snyder Mfg. Co. of Ohio, and distributed only by Zimmer Mfg. Co., Warsaw, Ind.

QUESTION: Who makes tablets for preserving urine specimens?
ANSWER: Ingram & Bell Limited, 256 McCaul St., Toronto 2B, Ont., Canada, distributes the "Speci-Fix" Urine Preservative Tablet, and Cambridge Chemical Co., 5850 Chase Rd., Dearborn, Mich., makes the #701 SFT Urine Preservative.

QUESTION: From whom is an electric rectal dilator heater and massager as formerly distributed by Electro Thermol Co. of Steubenville, Ohio available now?
ANSWER: Siebert and Company, 41 Rankin St., Newark 3, N. J. makes one, and the Peacock Surgical Company, Inc., 1235 Texas Ave., Shreveport, La. has a Siebert in stock which they will sell.

QUESTION: Who makes a blood bottle ring? Believed to be made in Canada.
ANSWER: Originated by Baxter Laboratories of Canada Limited, Alliston, Ontario, whose sales agents in Canada are Ingram & Bell Limited, 256 McCaul St., Toronto 2B, Ontario.

QUESTION: *Do you know the manufacturer of a fumigating machine (mist spray) used in sterilizing hospital rooms, the surgery room, etc?*
ANSWER: Wilmot Castle Co., 1777 E. Henrietta Rd., Rochester 18, N. Y. and Continental Laboratories, Inc., 499 Hamilton Ave., Palo Alto, Calif.

QUESTION: *Can you give us the source of supply of a plastic elastic band cutter for examining tables?*
ANSWER: American Metal Furniture, Inc., 930 W. New York St., Indianapolis 7, Ind.; Federal Medical Specialties Co., 69 Murray St., New York 7, N. Y.; Larrick Co., Inc., 103 Park Ave., New York 17, N. Y.: and Tidi Products, P. O. Box 166, 996 E. Price St., Pomona, Calif.

QUESTION: *Please advise who makes Towelettes, wash'n dri towels?*
ANSWER: R. R. Williams Co., Inc., Canaan, Conn.

QUESTION: *Does anyone make a disposable vaginal speculum?*
ANSWER: Robert Busse & Co., Inc., 64 E. 8th St. would consider making one.

QUESTION: *From whom are soft rubber ear speculums for otoscopes available?*
ANSWER: Hychex Products 5915 Northwest Highway, Chicago 31, Ill. and Rimmer Bros. Ltd., 18-19 Aylesbury St., Clerkenwell Green, London, E.C.1, Eng.

QUESTION: *We need a complete seat, preferably brown, of the now-discontinued Seat-O-Matic formerly distributed by Everest & Jennings. This is for the 8U-20 wheel chair.*
ANSWER: Fraiberg & Smith Surgical Co., 14423 Detroit Ave., Lakewood 7, Ohio has one which they will sell; and Scully-Walton, Inc., 505 E. 116th St., New York 29, N. Y. has a complete 8U20-15 chair including Seat-O-Matic in brown upholstery, which they can make available for sale.

QUESTION: *Advise name and address of the manufacturer of Smiths timers.*
ANSWER: Smiths Clocks & Watches Ltd., a division of S. Smith & Sons Ltd., Sectric House, Waterloo Road, London N.W.2, Eng.

QUESTION: *Who repairs the Exacta gauge?*
ANSWER: This is manufactured by Rudolf Riester, Jungingen/Hohensollern, Germany. Do not know American distributor but Canadian distributor is A. H. Jurgensen Co., 229 Yonge St., Toronto, Ont.

Hospitals Use Teletype

■ STATISTICS indicated more and more hospitals are realizing the advantages of teletype for rapid communication. The number of hospitals listed in Teletype Directory for the past three years is:

1959—19
1960—29
1961—35

A breakdown of the 35 shows seven states represented with the heavy concentration in Ohio, Kansas and Colorado.

Ohio	14
Kansas	9
Colorado	8
Arizona	1
Illinois	1
Oklahoma	1
West Virginia	1

Dates to Remember

September 25-28
63rd Annual Meeting of American Hospital Association, Convention Hall, Atlantic City, New Jersey.

September 28-29
National Association of Hospital Purchasing Agents, Atlantic City, New Jersey.

September 28 (afternoon)
Ritz Carlton Hotel, Green Room

September 28 (dinner)
Ritz Carlton Hotel, Carlton Room

September 29 (morning and afternoon)
Ritz Carlton Hotel, Green Room

Amsco's

VACAMATIC

out-produces any THREE ordinary sterilizers

Vacamatic is NOT an ordinary sterilizer. It doesn't even *look* ordinary.

This *new* Central Service Sterilizer utilizes advanced principles of sterilization to achieve its tremendous speed and positive efficiency. Vacamatic draws ultra-fast vacuums before and after each load, thus permitting instantly microbicidal pressure steam temperatures of 275°F.

In fact, so swift . . . so positive is Vacamatic that it processes a full load of linens in just *15 minutes* . . . in contrast to 70-80 minutes for ordinary sterilizers . . . *about five times faster.*

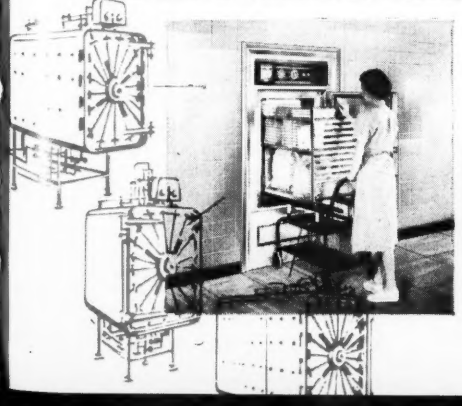
But *time* is not the only barrier Vacamatic overcomes. It provides *positive assurance* that even the most dense packs are properly sterilized (due to high prevacuum and instantly microbicidal action of pressure steam at 275° F.). Fabrics have *longer life* because of the ultra-short exposure period . . . and Vacamatic *saves vital space* in Central Service.

Smart styling of the new Vacamatic is in keeping with the most modern concepts of hospital decor. Handsome stainless steel facing plus an aqua and red control panel accent the beauty of Vacamatic.

And finally the easy operation of this advanced unit. The operator simply selects the type of load and presses the "Start" button. It's that simple . . . that *positive*. Vacamatic's "electronic brain" does all the rest.

Wouldn't a new high efficiency Vacamatic Sterilizer fit into your Central Service sterilization program?

Please write for "Vacamatic Breakthrough" Brochure SC-303.



AMERICAN STERILIZER
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World's largest designer and manufacturer of Sterilizers, Surgical Tables, Lights and related equipment and supplies for hospitals

Roop

Continued from page 50

be a step-by-step projection of the total program to assure that the buildings, grounds and equipment will be maintained in such a state of repair that will protect the investment in dollars that the tax payers, the citizens of your community, have invested in it. It is your responsibility, under state regulations and those of the Hill-Burton program, to maintain and efficiently operate the physical plant.

Preventive maintenance may mean simply a scheduled lubrication program, air filter maintenance and periodic but scheduled check of major appliances and equipment. The more complex your hospital, the greater the necessity for a preventive maintenance program. The administrator sets the standards of any maintenance program and he must support such a program in order to initiate and sustain it.

The formulation of operating standards for all equipment is an engineering management skill together with the necessary log, record or data sheets. Maintaining such log sheets is not enough. Such record keeping must also be accompanied with an analysis of the data in order to determine if the equipment is functioning efficiently and as designed. No system of preventive maintenance is worth much unless there is a sound system of requested maintenance. The development of such a system should include the following:

1. Internal procedures in the department for processing all work requests. This is the one spot where most programs have failed.
2. The role of the department requesting the work must be defined.
3. A means of follow-up after completion of the work order.

Fiscal Finances of Physical Plant Services

A monthly evaluation of expenditures for physical plant services is as necessary as an evaluation of your per patient day costs and their effects on hospital charges. The administrator can establish an annual budget for the engineering department by analyzing past records and applying that knowledge to the current needs.

What may we establish as a per patient day cost for these plant services that will be in line with that of other hospitals? The quality and standards of maintenance in your hospital will dictate the final results but here, as a starting point, let us look at the monthly per patient day costs for hospitals in one area for the last eight months of 1959.

Per Patient Day Costs for Plant Operations

1-101 Beds	101-225 Beds	Month and Year
$1.84	$2.28	Dec. 1959
$1.54	2.00	Nov. 1959
$1.49	1.76	Oct. 1959
$1.66	1.75	Sept. 1959
$2.13	2.00	Aug. 1959
$1.94	1.75	July 1959
$1.63	1.89	June 1959
$1.94	1.62	May 1959

Adopted from Hospital Management Magazine "How's Business"

The averages for this period are as follows:
1-100 beds $1.77 per patient day
101-225 $1.88 per patient day

The extremes in this tabulation do not appear in the winter months when fuel bills may be expected to be highest. An awareness of such trends in plant operating costs can save you money.

In the three basic utilities (water, fuel, electricity) you are spending from 21 to 26 percent of your total departmental operating budget. Utilities represent 15 percent of your total general costs of overhead — that is, expenses necessary for the maintenance and preservation of property, including housekeeping, insurance and depreciation.

Next to the cost of labor, these utilities represent the single highest item in the budget of the maintenance department. In a 100-bed hospital utility costs alone will account for nearly 47.5 cents of your per patient day costs, and yet this expense is accepted like the inevitable taxes we pay. However, there is one difference. Through a study and analysis of your operations in all utility areas, the maximum efficiency and use of such monies will be assured.

The study and effect of purchases for outside services is another important area where savings may be realized. Expenditures for material and supplies used in the day-to-day operations and maintenance of your hospital should not exceed approximately 31 percent of your labor costs. Some hospitals have been known to go as high as 87 percent and not be aware of this leak in the financial structure.

All or part of this analysis then shall lead to proper and adequate budgeting for

1. Payroll
2. Physical plant improvements and equipment purchases
3. Supplies and expense, including utilities
4. Charges to other departments

The development of principles and procedures to be followed in the negotiation and awarding of maintenance, construction and other contracts is important. Even the smallest hospital can ill afford to proceed on major expenditures without fair and reasonable assurance that competition and total evaluation of all qualified products and services is considered.

Engineering management skills and criteria are part of your administrative responsibilities. They represent and offer to you and your hospital time tested and efficient methods for improved patient services at lower costs. ■

Fire Extinguishers

■ THE two and one-half gallon soda acid extinguisher is by far and away the most common extinguisher used in hospitals. Unfortunately it has been found that hospital personnel familiar with this unit have been reluctant to employ it, thinking that once it is inverted and in operation, it cannot be stopped. By merely returning the unit to an upright position, the expelling gas will fizz out in the solution and stop the flow of liquid. It must be remembered, however, that the unit can only be used once and then must be recharged before using again. If an attempt is made to reuse the extinguisher without recharging, there will be no gas behind the discharge of water and the water will issue from the hose like pop beverage out of a bottle.

Another popular model is the carbon dioxide extinguisher recognizable by its bright red color. These units are felt to have, among other applications, particular advantages in kitchens, being of a size female personnel would be capable of operating. In many institutions they are either lacking or so located as to discourage women from going after them and returning with one for use in the emergency area. Experience has shown, too, as with the soda acid extinguisher, that hospital personnel are unfamiliar with the extremely short range of carbon dioxide units (7 to 10 feet) and unprepared for the loud rushing noise that accompanies their operation. ■ — *Hospital Bureau Inc.*

There IS a difference in the quality of

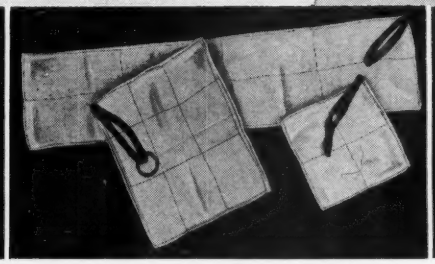
SURGICAL DRESSINGS

"Some time ago we were asked to make tests of surgical dressings. Frankly I was doubtful that there could be much difference, especially in the standard dressings we use in tremendous volume, such as, sponges, pads, cotton balls, and so on.

My choice after the tests was MARCO – they were *better* than any used previously. This was borne out by the staff's remarks about higher absorbency and softness, and uniformity of sizes and folds.

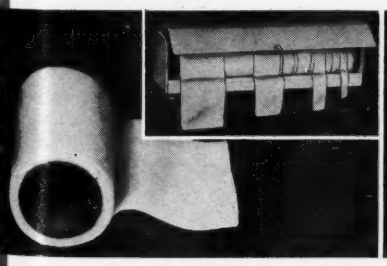
Besides, we also found the Marco people to be very resourceful in developing new dressings and in improving the quality and usefulness of old ones."

KE SPONGES highly X-ray detectable ent is spread throughout sponge. Non-matic to tissue. Bulk or pre-counted in , 3" x 3" to 8" x 4".

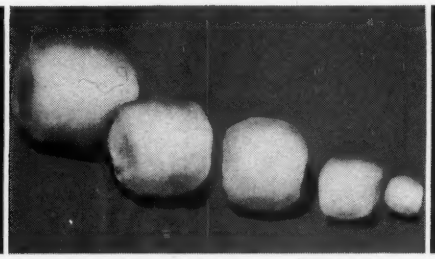


LAPAROTOMY TAPE PADS X-ray detectable, permanently bonded tape to attach to ring or hemostat. Quilted to hold shape, withstand repeated laundering. 12" x 12" or 18" x 18" square—18" x 4" or 36" x 8" oblong.

READY-CUT BANDAGE ROLLS sealed edges prevent thread ravelling. Flip-up flap on wrapper permits one-hand removal, controls unrolling—selfsealing to keep bandage clean. 10 yards long—all widths.



ESIVE provides minimum skin irritation, imum creep, no impurities. Firm fabric wrinkle-free application, effective support. eres with normal hand pressure. 10 yards " to 4".



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Defrosting Times of Frozen Turkeys

by Lenora Moragne and Karla Longree, Ph.D.
Department of Institution Management
Cornell University
Ithaca, New York

■ WHEN FROZEN TURKEYS are marketed they are usually accompanied by suggestions regarding method of defrosting and approximate defrosting time. The recommendation most commonly found is to defrost the bird in a refrigerator, an acceptable method from a bacteriological point of view. Yet under conditions of quantity food preparation, turkeys are sometimes allowed to defrost at room temperature in order to speed up the process. This nonrecommended method is apt to be used when time is pressing and when refrigerator space is limited.

A search of the literature revealed that information on the total defrosting times of turkeys at room temperature is scant[5,8] and no data were found which would shed light on the temperatures prevailing within the various body parts of the carcass while the turkey is defrosting. However, there is some information of temperature conditions within various body parts of small (13 lb.) frozen turkeys roasted from the frozen state.[6] Information on temperatures prevailing in various body parts of the carcass when defrosting at room temperature would be valuable in view of certain bacteriological implications. Therefore a study was conducted to determine the comparative defrosting times of various size turkeys, defrosted in and out of the refrigerator and with and without wrappings.

Materials and Plan of Study

Empire White turkeys,* two specimens within each of three weight classes, were used for these tests. The turkeys weighed: in the 8-lb. class, 3940 gm. and 4120 gm.; in the 14-lb. class, 6010 gm. and 6770 gm.; and in the 20-lb. class, 9204 gm. and 9307 gm. The birds in the weight classes of 8 to 14 lb. were 16 weeks old, those in the 20-lb. class, 24 weeks old.

The giblets and the neck were placed in the body cavity before the birds were frozen; the giblets were positioned in the anterior portion and the neck in the posterior portion of the cavity in such a manner that several cubic inches of air space remained in the center of the cavity. The legs were tied together and the turkeys were wrapped** before freezing. The wrappings were removed from the birds just before defrosting in the birds to be defrosted unwrapped. One and the same bird was used for several treatments so that at the end of the study each carcass had been defrosted and refrozen several times. The birds were frozen and stored at temperatures well below 0°F. Within each class the experimental treatments were as follows: defrosted wrapped and unwrapped; defrosted at refrigerator temperature and at room temperature.

*The donation of the turkeys by the Department of Poultry Husbandry is gratefully acknowledged.

**"Cry-O-Vac" bags.

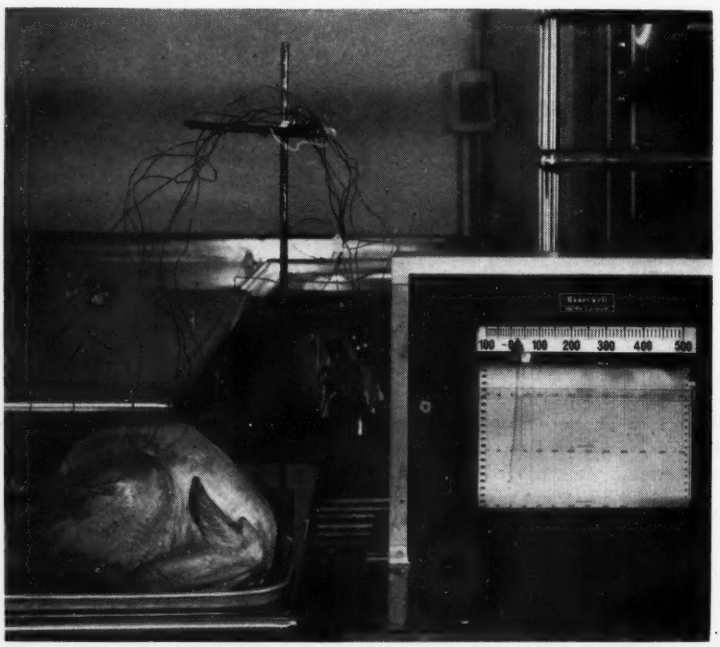

Figure 1. Turkey defrosting at room temperature with the thermocouples in position and the recording potentiometer by the side.

Thanks are due Dr. Robert C. Baker, Department of Poultry Husbandry, for his aid in selecting the positions of the thermocouples in the turkey carcass; and to Dr. James C. White, Department of Dairy and Food Science, for his critical reading of the manuscript.

Temperature Determinations

To collect temperature data which would give an indication of the total defrosting times as well as the times during which certain selected parts of the turkey remained relatively warm until the whole carcass was defrosted, temperatures were determined using thermocouples which were placed in position before the turkeys were frozen. At the start of the defrosting the thermocouples were plugged into a recording potentiometer† *(Figure 1)*.

The thermocouples were positioned in seven parts of the turkey at various depths: in the "inner" thigh (m. biceps femoris), 1-½ in. below the skin in the 8-lb. turkey, 2-½ in. below the skin in the 14-lb. turkey, and 3-½ in. below the skin in the 20-lb. turkey; in the "inner" breast (m.m. pectoralis), 1 in. below the skin in the 8-lb. turkey, 2 in. below the skin in the 14-lb turkey, and 2-½ in. below the skin in the 20-lb. turkey; in the breast (m. pectoralis superficialis), 1 in. below the skin and in the area directly below the skin; in the leg (m. peroneus longus) ½ in. below the skin and in the area directly below the skin; and in the body cavity in the air space between the giblets and the neck, where the thermocouple was held in place by a cork to prevent it from touching any body parts.

Table 1. The total time (days) necessary for the turkeys to defrost, as influenced by various conditions of defrosting.*

Turkey Weight Class (lb.)	Refrigerator Temperature		Room Temperature	
	Bag	No Bag	Bag	No Bag
8	2.0	1.3	.5	.4
14	2.3	1.7	.7	.5
20	3.0	2.4	.8	.7

*Average of two turkeys.

The terms "inner" thigh and "inner" breast refer to the area in the trussed turkey where the thigh touches the breast. The turkeys were considered defrosted when the "inner" thigh region reached 33°F.; at this time the thigh and legs were quite pliable. Pliability began at 28°F. A temperature of 28°F. has been reported as an average freezing point of foods in general.[2,3]

A 55 cu. ft. institution reach-in refrigerator‡ equipped with a 10-in. diameter fan with intermittent operation was used. The temperature in the refrigerator ranged from 33°F. to 37°F. During the first three hours following the positioning of the turkey the temperature went occasionally as high as 40°F. When defrosted at room temperature, the turkeys were placed on a cart in the laboratory where the average temperature range was 68°F. to 72°F.

†Minneapolis-Honeywell, model Y153 X 60P (S) 8-X-31.

‡Jewett, General Electric model CS-450.

Defrosting Times of Turkeys

The results of the study on total defrosting times are presented in *table 1.* Defrosting in the refrigerator took three to four times as long as defrosting at room temperature. The presence of the wrapping made more difference when the turkeys were defrosted in the refrigerator than when defrosting took place at room temperature. Regardless of defrosting conditions, the defrosting times for the 20-lb. birds were approximately 1-½ to 2 times as long as for the 8-lb. birds; the times for the 14-lb. birds were in between. For turkeys defrosted in the refrigerator, the times established under the conditions of this study agree in general with the times suggested by the poultry packers and the times quoted in the literature[5] for corresponding weight classes of turkeys.

The total defrosting times established for turkeys allowed to defrost at room temperature were considerably shorter than the two hours per pound of turkey as quoted by Tressler.[5] Defrosting times may vary with kitchen temperatures, but it should be pointed out that the temperatures used in this study were not very

Table 2. The total time (in hours) necessary for some selected parts of the turkeys to pass through certain temperature ranges, as influenced by various conditions of defrosting.

Thermocouple Position	Turkey Weight Class (lb.)	Refrigerator Temperature						Room Temperature							
		Bag			No Bag			Bag				No Bag			
		0°-27°F.	28°-32°F.	33°F. & above	0°-27°F.	28°-32°F.	33°F. & above	0°-27°F.	28°-40°F.	41°-50°F.	51°F. & above	0°-27°F.	28°-40°F.	41°-50°F.	51°F. & above
Inner thigh	8	39.83	9.0	*	19.66	10.5	*	9.16	3.83	none	none	8.5	1.66	none	none
Breast skin		4.33	31.16	13.33	4.08	14.74	12.0	.83	.66	4.33	6.66	.16	3.58	5.08	1.5
Leg skin		7.08	17.41	24.0	3.33	12.0	11.66	.91	1.83	7.08	2.91	.08	2.58	6.16	1.41
Leg ½ in.		18.0	16.41	14.41	11.75	16.0	2.5	3.25	2.75	4.75	.58	1.16	4.41	4.58	none
Breast 1 in.		26.75	19.0	3.08	12.08	15.83	3.25	3.66	7.41	1.75	none	4.0	5.41	.75	none
Inner breast		24.75	21.75	2.33	19.75	10.25	none	11.16	3.91	none	none	5.83	5.58	none	none
Cavity		43.33	3.16	none	23.5	6.5	none	9.16	3.66	none	none	9.58	.58	none	none
Inner thigh	14	40.5	14.33	*	21.5	20.0	*	15.0	1.0	none	none	9.41	1.75	none	none
Breast skin		8.25	10.0	29.66	13.0	15.5	6.0	.16	1.58	9.91	4.41	.33	2.25	6.33	2.83
Leg skin		6.66	7.5	33.75	2.0	12.08	20.0	.16	3.66	7.91	4.33	.25	1.41	5.58	4.41
Leg ½ in.		10.0	20.41	17.41	18.0	9.0	5.0	2.08	6.83	6.33	.75	2.5	4.58	3.41	1.16
Breast 1 in.		25.5	22.66	none	15.0	15.25	5.0	6.16	6.33	3.66	none	6.0	4.5	1.25	none
Inner breast		48.0	5.66	1.5	29.0	5.0	.16	13.66	2.33	none	none	10.0	1.66	none	none
Cavity		42.25	6.08	none	31.5	none	none	15.49	.5	none	none	11.75	none	none	none
Inner thigh	20	62.83	9.41	*	44.25	13.58	*	16.41	1.75	none	none	15.33	1.5	none	none
Breast skin		15.5	36.25	18.5	10.5	32.5	14.83	1.75	3.25	5.75	7.41	.5	2.58	12.08	2.0
Leg skin		7.58	24.83	39.66	2.33	5.91	49.75	2.91	3.0	3.66	7.83	.08	2.25	7.5	7.16
Leg ½ in.		26.0	34.5	11.41	12.75	20.58	24.41	1.91	4.5	5.16	6.58	3.5	6.0	7.33	none
Breast 1 in.		38.25	29.25	5.25	27.5	21.75	8.58	9.0	6.5	2.66	none	8.83	7.25	.75	none
Inner breast		58.25	14.0	none	39.5	9.75	8.58	17.25	.91	none	none	14.41	2.41	none	none
Cavity		64.33	7.91	none	47.5	10.33	none	16.25	1.91	none	none	14.0	2.83	none	none

*Reached endpoint of 33°F.

high (68°F. to 72°F.) and defrosting times may be expected to be shorter at higher room temperatures. On the other hand, defrosting times should be expected to be somewhat longer whenever the starting temperature of the frozen turkey is lower than the starting temperature used in this study, 0°F. It was found that relatively little time was needed to raise the internal temperature of turkeys from −20°F. to 0°F. For example, to raise the temperature in the "inner" thigh of wrapped 20-lb. turkeys, 1.16 hr. were required when defrosting at room temperature and 1.83 hr. when defrosting at refrigerator temperature.

Defrosting Times of Individual Body Parts

The results of the study on temperature changes in the individual body parts and the final temperatures reached in these parts are presented in *tables 2 and 3*, respectively. The data show that the total times required for these parts to pass through certain temperature ranges were much influenced by the variables studied, but some general facts stand out. The area just below the skin defrosted first, then the leg meat followed by the breast meat, the "inner" breast, "inner" thigh, and finally the body cavity.

When the turkeys were defrosted in the refrigerator, all parts remained below 35°F. throughout the defrosting period. When the turkeys were defrosted at room temperature, the history of the temperature of the various body parts was as follows: the area just below the skin of the turkeys remained over 40°F. for an average of 11 hr., and 4 hr. of these were above 50°F. The leg meat remained at temperatures above 40°F. for an average of 7 hr., and 1.5 hr. of these were above 50°F. The breast meat remained at temperatures over 40°F. for 2 hr. and never reached 50°F. The "inner" thigh and "inner" breast areas never reached 41°F.

The body cavity remained quite cold throughout the defrosting period. Regardless of the conditions of defrosting, the temperatures in the cavity of the carcass remained below 35°F. in all but one instance, when a temperature of 39°F. was reached. It was also found that the giblets were still in the frozen state when the carcass itself had reached the defrosted stage, regardless of the conditions of defrosting.

Discussion of Findings

These findings are interesting from a bacteriological viewpoint. Besides many other forms of bacteria associated with commercially dressed poultry,[3] Salmonella, a food poisoning organism, is found on fowl.[4] The contaminants may lodge on the outer skin as well as in the body cavity. According to McCullough[7] Salmonella was reported to have also been recovered from the skin of frozen turkeys freezer-stored for over a year.

In the present study it was shown that the skin of the turkeys defrosted at room temperature remained over 40°F. for 11 hr.; during 4 hr. of these 11 hr. the temperature was above 50°F. It is possible that some multiplication of the contaminants took place during this 11-hr. period, especially if the contamination was a heavy one. It therefore seems that the practice of thoroughly washing defrosted turkeys prior to cooking is an excellent one.

On the basis of this study, the cavity of the carcass remained well below 40°F. under all conditions of defrosting, even when the birds were defrosted at room temperature. But a word of caution is in order. These temperature data were obtained using turkeys which were defrosted while the giblets were in the cavity of the carcass. It must be expected that conditions would be more favorable for bacterial multiplication if the cavity were left open, and the access of warm air into the interior were not obstructed.

On the basis of his research, Angelotti[2] concluded that "if perishable foods are to be stored for extended periods, internal temperature of the food should be maintained at or below 42°F. in order to prevent the growth of salmonellae and staphylococci."

Summary

Under conditions of quality food preparation turkeys are sometimes allowed to defrost at room temperature in order to speed up the process. Information on temperatures prevailing in various body parts of the carcass when defrosting at room temperature would be valuable in view of certain bacteriological implications. Therefore a study was conducted to determine the comparative defrosting times of various size turkeys, defrosted in and out of the refrigerator, and with and without wrappings. The turkeys were considered defrosted when the "inner" thigh, the area where the thigh touches the breast in a trussed turkey, reached 33°F.

Defrosting in the refrigerator took three to four times as long as defrosting at room temperature. The presence of the wrapping made more difference in prolonging defrosting time when the turkeys were defrosted in the refrigerator than when defrosting took place at room temperature. Regardless of defrosting conditions, the defrosting times of

Table 3. The final temperatures (° F.) reached by some selected parts of the turkeys, as influenced by various conditions of defrosting.

		Refrigerator Temperature				Room Temperature					
		Bag		No Bag		Bag			No Bag		
Thermocouple Position	Turkey Weight Class (lb.)	28°-32°F.	33°F. & above	28°-32°F.	33°F. & above	28°-40°F.	41°-50°F.	51°F. & above	28°-40°F.	41°-50°F.	51°F. & above
Inner thigh	8		33		33	33			33		
Breast skin			34		35			60			51
Leg skin			34		35			51			52
Leg ½ in.			34		33			52		47	
Breast 1 in.			34		33		45			42	
Inner breast			33	32			41		39		
Cavity		32		31		37			30		
Inner thigh	14		33		33	33			33		
Breast skin			35		34			53			54
Leg skin			35		34			55			58
Leg ½ in.			34		33			52			53
Breast 1 in.			33		33		48			43	
Inner breast			33		33	36			32		
Cavity		29		*		29			*		
Inner thigh	20		33		33	33			33		
Breast skin			35		35			57			54
Leg skin			35		35			57			55
Leg ½ in.			34		34			57		50	
Breast 1 in.			33		34		44			42	
Inner breast			33		34	32			35		
Cavity		30		30		32			32		

*Temperatures never reached 28°F.

the 20-lb. birds were approximately 1-½ to 2 times as long as for the 8-lb. birds; the times for the 14-lb. turkeys were in between.

The total time required for seven selected parts of the carcass to pass through certain temperature ranges were much influenced by the variables studied. In general, the areas just below the skin defrosted first, then the leg meat, followed by the breast meat, the "inner" breast, "inner" thigh and, finally, the body cavity. When the turkeys were defrosted in the refrigerator, all parts remained below 35°F. throughout the defrosting. When the turkeys were defrosted at room temperature the skin of the turkeys remained over 40°F. for an average of 11 hr., and 4 hr. of these were above 50°F. The leg meat remained at temperatures above 40°F. for an average of 7 hr., and 1.5 hr. of these were above 50°F. The breast meat remained at temperatures over 40°F. for 2 hr. and never reached 50°F. The remaining body parts never reached 41°F. Regardless of the conditions of defrosting, the temperatures in the cavity of the carcass remained below 35°F. in all but one instance when a temperature of 39°F. was reached.

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Kathleen McGee

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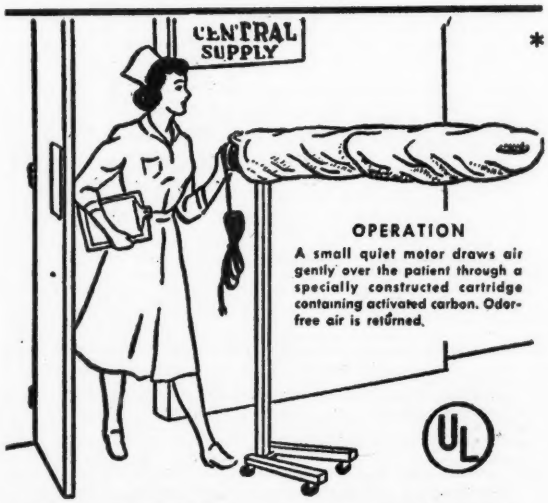

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HOSPITAL MANAGEMENT'S

monthly menus

1

Canaloupe wedge
Hot or ready to eat cereal
3 minute egg
Toast

•

Roast fresh ham
Potato cakes
Beet greens
Stuffed celery sticks
Green apple sauce

•

Vegetable soup
Salisbury steak
New potatoes in cream
Shredded lettuce salad
Blueberry cobbler

2

Fresh peaches in cream
Hot or ready to eat cereal
Canadian bacon
Orange coffee cake

•

Lamb chop
Riced potatoes
Buttered broccoli
Krispy relishes
Butterscotch refrigerator roll

•

Cream of pea soup
Chili on cornbread
Frozen fruit salad
Gelatine cubes

3

Cinnamon prunes
Hot or ready to eat cereal
Baked egg
Toast

•

Roast beef
Golden brown potatoes
Escalloped eggplant
Strawberry aspic salad ring
Lemon filled cookies

•

Cream of tomato soup
Veal stew
Asparagus pimiento salad
Baking powder biscuits
Four fruit pudding

4

Grapefruit juice
Hot or ready to eat cereal
Scrambled eggs
Toast

•

Chicken pot pie
New potatoes in jackets
Creole celery
Tossed salad greens
Jellied fruit dessert

•

Cream of mushroom soup
Grilled ham slice
Potato salad
Tomato wedges
Chocolate cup cake

5

Bananas in cream
Hot or ready to eat cereal
Link sausage
Danish coffee twist

•

Cubed steak
Shoestring potatoes
Pimiento cauliflower
Pickle relish salad
Lime lemon sherbet

•

Consomme
Toasted chicken sandwich
Baby green limas
Olives-celery curls
Fruit bars

6

Applesauce
Hot or ready to eat cereal
Poached egg
Toast

•

Minted fillet of lamb
Cottage potatoes
Broccoli
Red cabbage slaw
Fruit au gratin

•

Cream of tomato soup
Braised tongue-horseradish sauce
Potato croquettes
Cheese ball salad
Peach shortcake

7

Red plums
Hot or ready to eat cereal
3 minute egg
Cinnamon toast

•

Broiled smelts-tomato sauce
Escalloped potatoes
Buttered wax beans
Lettuce wedge-herb dressing
Peach tapioca

•

Mongole soup
Tuna fish and cabbage tossup
Harvard beets
Poppyseed twists
Lemon meringue tart

8

Honeydew melon
Hot or ready to eat cereal
Oven French toast
Syrup

•

Prime ribs of beef
Roast potato balls
Fresh spinach-lemon
Jellied fruit salad
Floating island

•

Cream of celery soup
Sausage pattie-apple ring
Duchess potatoes
Pepper slaw
Bing cherries

9

Berries-cream
Hot or ready to eat cereal
Crisp bacon
Muffins-jelly

•

Oven fried chicken
Candied sweet potatoes
Garden peas
Olives-Radish roses
Pistachio ice cream

•

Pepperpot soup
Creamed dried beef
Fluffy rice
Julienne vegetable salad
Sugared doughnut

10

Orange juice
Hot or ready to eat cereal
Omelet
Toast

•

Cubed steak
Grilled potato slices
Silvered carrots
Waldorf salad
Cornflake pudding

•

Vegetable soup
Grilled cheese sandwich
Asparagus cuts
Fruit layer salad
Pecan tart

11

Grapefruit sections
Hot or ready to eat cereal
Scrambled egg
Toast

•

Swiss steak
Whipped potatoes
Yellow squash
Lettuce wedge, French dressing
Boysenberry crisp

•

Split pea soup
Hot turkey biscuit sandwich
New corn and lima beans
Tomato endive salad
Fresh apricots

12

Tomato juice
Hot or ready to eat cereal
Bacon curls
Cinnamon bun

•

Roast leg of lamb
Franconia potatoes
Minted carrots
Mexican salad
Banana refrigerator cake

•

Golden potato soup
Stuffed pepper
Diced beets
Jellied cherry salad
Chocolate cup cake

13

Fruit nectar
Hot or ready to eat cereal
3 minute egg
Toast

•

Roast leg of lamb currant jelly
Potato rissole
Wax beans
Apricot macaroon salad
Chocolate ice box cookies

•

Vegetable beef soup
Assorted luncheon meats
Baked potato
Tomato wedge and
hard cooked egg salad
Baked rice pudding

14

Kadota figs
Hot or ready to eat cereal
Scrambled eggs
Toast

•

Baked stuffed bass
Buttered crumb potatoes
Pickled beets
Wilted spinach salad
Orange gingerbread

•

Chilled fruit juice
Crabmeat salad
Potato puff
Assorted relishes
Apricot bavarian cream

15

Rhubarb sauce
Hot or ready to eat cereal
Poached egg on toast

•

Vegetable soup
Hamburger — bun
Succotash
Wilted lettuce
Cherry cobbler

•

Pork tenderloin
Mashed potatoes
Cauliflower au gratin
Beet relish salad
Escalloped apples

16

Blended fruit juice
Hot or ready to eat cereal
Crisp bacon
Swedish rolls

•

Carolina meat pie
Fresh asparagus, vinaigrette
Lettuce heart
Blueberry upside down cake

•

Alphabet soup
Braised sirloin tips
Potato cakes
Julienne vegetable salad
Apple Betty deluxe

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17

Honey dew melon
Hot or ready to eat cereal
Crisp bacon
Swedish rolls

●

Breaded veal chop
Sweet potatoes, glace
Buttered peas and mushrooms
Perfection salad
Butter pecan ice cream

●

French onion soup
Chicken livers with rice
Crusty French bread
Molded fruit salad
Brownies

18

Tomato juice
Hot or ready to eat cereal
French toast
Jelly

●

Steak and kidney pie
New potatoes
Pimiento wax beans
Carrot raisin salad
Fresh fruit cup

●

Corn chowder
Cheese stuffed frankfurter-buns
Lyonnaise potatoes
Grated vegetable salad
Marble cake

19

Pineapple wedges
Hot or ready to eat cereal
Bacon curls
Popovers-jelly

●

Oven baked chicken
Whipped potatoes
Summer squash
Watermelon pickles
Ice cream sundae

●

Vegetable soup
Assorted luncheon meats
Baked bean casserole
Fresh fruit salad
Cornflake macaroons

20

Prune juice
Hot or ready to eat cereal
Omelet
Toast

●

Grilled lamb pattie
Parslied buttered potatoes
Broiled tomato half
Cole slaw
Carmel blanc mange

●

Jellied consomme
Veal paprika
Buttered noodles
Garden salad
Raspberry tart, whipped cream

21

Grapefruit half
Hot or ready to eat cereal
Baked egg
Toast

●

Clam chowder
Macaroni au gratin
Garden peas
Fresh fruit salad
Jelly roll

●

Lake trout-pimiento sauce
Cream diced potatoes
Swiss chard
Perfection salad
Cake top lemon pudding

22

Bananas in cream
Hot or ready to eat cereal
Shirred egg
Toast

●

Savory meat loaf
Stuffed baked potato
Creamed tiny onions
Fruit salad
Yellow cup cake

●

Tomato chowder
Canadian bacon
Corn fritters-syrup
Lettuce-Thousand Island Dressing
Iced apricot tart

23

Fresh grapes
Hot or ready to eat cereal
Crisp bacon
Coffee cake

●

Veal steak, Parmesan
Mashed potatoes
Zucchini, Creole
Tossed salad greens
Melon cup

●

Bouillon
Spaghetti Italienne with meat sauce
Cut green beans
Endive, oil and vinegar dressing
Fruit cocktail

24

Fresh grapes
Hot or ready to eat cereal
Toast

●

German pot roast
Hash brown potatoes
Dutch spinach
Raw vegetable relishes
Chilled prunes-lemon custard sauce

●

Potato chowder
Jellied veal loaf
Carrots in cream
Pickled baby beet salad
Minted fruit cup
Nabiscoes

25

Cantaloupe
Hot or ready to eat cereal
Frizzled beef on toast

●

Savory veal roast
Escalloped potatoes
Mexican corn
Pineapple cheese salad
Bing cherries

●

Cream of celery soup
Shepherd's pie
Broccoli
Jellied fruit salad
Fresh peach shortcake, whipped cream

26

Purple plums
Hot or ready to eat cereal
3 minute egg
Toast

●

Pot roast of beef
Browned potatoes
Diced carrots
Chiffonade salad
Cabinet pudding-cherry sauce

●

Roast pork
Mashed potatoes
Stewed tomatoes and okra
Cucumbers-sour cream dressing
Apple date cobbler

27

Devils food cake
Cantaloupe
Hot or ready to eat cereal
Crisp bacon strips
Kolaci

●

Barbecued short ribs of beef
Hash brown potatoes
Buttered peas
Tomato watercress salad
Peanut brittle pudding

●

Clear tomato soup
Chicken pot pie
Broccoli
Grapefruit apple pinwheel salad
Refrigerator cheese cake

28

Apricot nectar
Hot or ready to eat cereal
Shirred egg
Toast

●

Noodle soup
Devilled eggs-sardines on toast
French fried potatoes
Tomato cottage cheese aspic
Pineapple orange sherbet

●

Swiss potato soup
Cheese platter
Shredded beets in orange sauce
Grape-melon ball salad
Ice box cookies

29

Orange slices
Hot or ready to eat cereal
3 minute egg
Toast

●

Smothered steak
Whipped potatoes
Celery and carrots
Banana nut salad
Marshmallow date roll

●

Vegetable beef soup
Chicken a la king on toast points
Julienne green beans
Golden glow salad
Strawberry macaroon float

30

Pineapple juice
Hot or ready to eat cereal
Griddle cakes
Syrup

●

Beef a la mode
Succotash
Broiled tomato half
Sunburst fruit salad
Marble cake

●

Consomme
Grilled ham and eggs
Baked potato
Brussels sprouts
Shredded lettuce, Russian dressing
Watermelon cubes

31

Orange tidbits
Hot or ready to eat cereal
3 minute egg
Raisin toast

●

Pan broiled liver
Potatoes, rissole
French green beans
Garden salad
Chilled watermelon

●

Rice soup
Ham roll-ups
Corn on the cob
Endive salad

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Vegetable Ribbon Mold — 32 portions

Ingredients	Wt or Amt	Measure
Lemon jell-o	1 lb	2 1/3 c
Hot water (140 to 160°)		2½ qt
Vinegar		½ c
Salt	1½ oz	3 tbsp
Grated or finely ground raw carrots	1 lb	1 qt
Finely chopped raw cabbage	1 lb	1 qt
Finely chopped raw spinach	10 oz	1 qt
Finely cut green onions		2 tbsp

Dissolve jell-o in hot water; add vinegar and salt; divide into three equal parts.

Chill one part until mixture is slightly thickened; then add grated carrots and turn into loaf pans to depth of 1-inch; chill until firm.

Chill second part until slightly thickened; fold in cabbage and turn over firm carrot layer in pans; chill until firm.

Chill third part until slightly thickened; combine spinach and onions; fold into slightly thickened jell-o; turn over firm layers in pans; chill until firm.

Unmold and cut in slices; serve on crisp lettuce; garnish with mayonnaise.

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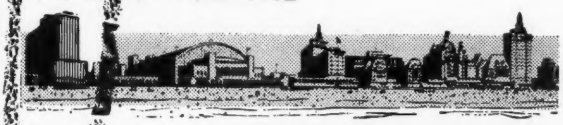

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pharmacy

by Daniel F. Moravec, M.Sc.

More About Anti-depressant Drugs

by Inese Z. Ziedins

Editor's Note: This is the last half of an excellent article presented by Miss Ziedins to the seminar of Graduate Students and Faculty of the College of Pharmacy, University of Nebraska, December, 1960.

■ A more rapid and potent monoamine oxidase inhibitor (MAO) is *Pheniprazine* (Catron, Lakeside). Chemically b-phenylisopropylhydrazine, this compound has the optimum structure for inhibiting brain MAO: and unsubstituted benzene ring, an isopropyl or ethyl side chain and a terminal unsubstituted hydrazine group. The structural requirement for optimum central stimulatory properties is the 1-phenyl-2-propyl skeleton. The hydrazine group imparts potent MAO inhibitory properties. The benzene ring is extremely important in brain selectivity by allowing its ready passage across the blood-brain barrier. The significance of this structure-activity relationship is that drugs possessing higher brain selectivity minimize accumulation in the liver and other peripheral tissues and thus there are less side effects. This drug does, however, have side effects, but to a lesser degree than with the former two drugs. Hypotension and liver damage are the more important ones. Color vision-reversible red-green color defect has been observed. The drug must. be discontinued if this occurs. Catron is given 12 mg. once daily for two weeks, then reduced to 6 mg. and then to 3 mg. daily. Since it is a very potent drug, the manufacturer has made several precautionary statements in literature and packaging: the daily dose should not be over 12 mg., it is to be reduced as soon as possible; regular liver function tests must be performed; the drug should not be prescribed more than necessary; the prescription should be marked "Not refillable."

Phenelzine (Nardi, Warner-Chilcott), chemically b-phenylethylhydrazine, is best for milder type depressions. Side effects are reported to be nonserious and rare, but the drug should not be given to patients with a history of liver disease or damage, which is true of all MAO inhibitors. The initial dosage is 45 mg. daily in divided doses. Improvement is seen usually within a week. Dosage should be reduced slowly to a maintenance level of 15 mg. daily or every other day.

Nialamide (*Niamid, Pfizer*) chemically a more complex molecule than the drugs mentioned this far, is 1-/2-(benzylcarbamyl)-ethyl 1/-2-isonicotinylhydrazine.

Indicated in a variety of depressive syndromes, the drug is of reportedly extremely low toxicity and is well tolerated. Side effects are nonserious, like some anticholinergic effects. The starting dose is 75 mg. daily, which is increased or decreased as needed. Up to 450 mg. daily have been given.

Tranylcypromine (Parnate, SK&F) is a new MAO inhibitor. Chemically, trans-dl-2-phenylcyclopropylamine, it is a nonhydrazine, one of a series of new drugs being investigated in the treatment of depression. It is the most potent MAO inhibitor available, with the following unique properties; it is a nonhydrazine, which may account for its apparent safety; it has a bimodal stimulating action: a rapid, direct action similar to that of the amphetamines to which it is related, and also it has the slow, cumulative, indirect action of the other MAO inhibitors. It seems to be more quickly effective than the former drugs; however, improvement is subtle in onset. Side effects are relatively few, like headache, insomnia and dizziness. It is effective in small doses, 10 mg. b.i.d. Indicated in the treatment of any type of depression, it is reported to be satisfactory in 77 percent of patients. The drug is also marketed in combination with Trifluoperazine (Stelazine, SKF) as Parstelin, SKF. The tablet contains 10 mg. Tranylcypromine and 1 mg. Trifluoperazine.

Inese Z. Ziedins

The last group can be classified as Miscellaneous Antidepressants (or "other antidepressives").

Two chemically related compounds which have become popular recently are piperidine derivatives. They are *Pipradol* (Meratran, Merrell) and *Methylphenidate* HCl (Ritalin, Ciba). Ritalin is chemically methyl-a-phenyl-a-2-piperidyl acetate, and is a CNS stimulant, stimulating the cortical or psychomotor areas. There is no depressive rebound; it exerts a plateau type of stimulation, smooth in onset and gradually tapering off. More useful in neurotic than frank psychotic conditions, it is given usually 10 mg. b.i.d. or t.i.d., but up to 60 mg. may be given. Side effects are rare and are usually of anticholinergic nature. Ritalin is available as oral and parenteral preparations. Studies show that IV Ritalin has greater and more immediate effects than its oral dose.

The author is Senior Hospital Pharmacy Resident, Lincoln General Hospital, Lincoln, Nebraska.

Pipradol (Meratran, Merrell), chemically a-(2-piperidyl) benzhydrol, influences that portion of the brain concerned with the function of alerting. It is not a sympathomimetic amine and has no effect on peripheral nervous or cardiovascular systems. Indicated mainly in mild reactive depressions, dosage is 1-2 mg. t.i.d., but up to 7.5 mg. are sometimes given. As a side effect one may have behavioral toxicity. Appetite is not affected.

Imipramine HCl (Tofranil, Geigy) is a dibenzazepine derivative, chemically 5-(3-dimethylaminopropyl) -10, 11-dihydro-SH-dibenz-/b, f/-azepine HCl.

Geigy calls this compound a "thymoleptic," because it acts specifically to ameliorate pathologic depressive states but does not act as a CNS stimulant in the absence of depression. The term is derived from the Greek roots *thymos* (mood, spirit) and *leptos* (to change, to influence); its mode of action has not yet been clearly defined. It has been suggested that it exerts antidepressant effects by virtue of sensitization of central adrenergic synapses but this has not been proven. It does not potentiate tranquilizers or barbiturates, which is a definite advantage. "Tofranil" is indicated in mild-severe depressions, especially of endogenous nature. Neither tolerance nor habituation have been observed. It is interesting to note the changes occurring in the depressive phenomenology concomitant with Imipramine administration: a shift from internal to external object relation, diminution of guilt feeling, redistribution of aggressive drives, reappearance of predepression, basic personality pattern. It is reported to have produced effective results in 70 to 85 percent of the cases. Improvement is usually seen in three days to three weeks. The dosage for inpatients is up to 300 mg. daily and for outpatients, 200 mg. daily. Maintenance therapy is usually 50 to 150 mg. daily. The dosage schedule must be adjusted to the individual patient, and must be continued for at least a month after depressive symptoms have disappeared to avoid relapse. "Tofranil" is available in both tablet and injection form. Side effects are infrequent. One investigator has reported side effects in 3.5 percent of his cases. Agitation and dizziness are the most frequent side

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effects. H. E. Lehmann reports* the use of combined pharmaco-fever treatment with Imipramine and Typhoid Vaccine. The Typhoid Vaccine is given IV in several doses to obtain artificial pyrexia. Imipramine is then administered. The fever lowers the blood-brain barrier and facilitates the passing of the chemical substance from the circulatory system into the brain and surrounding cerebrospinal fluid. This therapy was used in the management of special clinical problem depressed patients, such as acute suicidal patients. The benefit is the shortening of the time lag between the start of treatment with the drug and the first significant improvement.

Deanol (Deaner, Riker), chemically 2-dimethylaminoethyl-4-acetylaminobenzoate, is believed to be a precursor to acetylcholine. It is speculated that it exerts an antidepressant effect by virtue of sensitization of central adrenergic synapses. It may be converted to acetylcholine within the cells of the CNS, but this is not proven. It is low in toxicity and is indicated in mild depressions. Effects come on gradually and are prolonged without a sudden letdown on discontinuation of therapy. Side effects are mild: temporary constipation and muscle tenseness. Dosage is initially 25 mg. daily in the morning; maintenance dose is 25 to 75 mg. daily.

Benactyzine has been known since 1936. Chemically, 2-diethylaminoethyl benzilate, it is marketed as "Suavitil" by MS&D and as "Phobex" by Lloyd, Dabney & Westerfield, Inc. This is an anticholinergic substance that acts on the CNS by raising the emotional threshold for disturbing enviromental stimuli. It blocks certain nerve impulses in the hypothalamus and protects the higher brain centers against psychic stress. It is not a stimulant. *Benactyzine* is mildly antidepressant, which effect appears to be due to the strengthening of the ego boundaries rather than to diminution of excitability. It acts rapidly, with no accumulation of effect and no euphoria. Effects are subtle. Initial dose is 1 mg. t.i.d., which is gradually increased to 3 mg. t.i.d. if needed. Side effects include dizziness, ataxia, feeling of relaxation of striated muscles and absentmindedness.

Benactyzine is used together with Meprobamate as Deprol, Wallace. Meprobamate is a CNS relaxant with a selective action on the thalamus, which reduces tension, anxiety and excitability without significant cortical inhibition. Benactyzine with its antidepressant action reduces autonomic response to emotion-provoking stress. Both of these effects are needed to combat depression. Side effects are minimal; no liver toxicity is reported.

The newest drug for depression, which is described in an article in the *American Journal of Psychiatry*, the November, 1960 issue, is Elavil, made by Merck. It is reported to have clinical effectiveness comparable with the presently available antidepressant drugs. It is not a MAO inhibitor. Chemically, 5-(3-dimethylamino-propylidine)-dibenzo/a,d/ /1,4/cycloheptadiene HCl, it structurally resembles Imipramine and shows the same spectrum of pharmacologic activty. Large doses can be given IM or IV without side effects other than drowsiness. It acts both as a tranquilizer and antidepressant.

*American Journal of Psychiatry, October, 1960.

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I know that you may have spent a lot of hospital money working-up a patient, so to speak, only to see him sign out "against advice," but this is no reason for being angry at him, especially when you may have been the cause of his distrust or impatience. As Goldwater pointed out long ago, such a patient is his own enemy; he may not be an enemy of the hospital!

•

The author who publishes an article presumably has something to teach and the one who reads it something to learn. Choose your author as you would choose your classroom teacher or lecturer. Increase your respect for him when his thesis is original with him or, if it is not, when he gives proper credit to the inspiring author who preceded him.

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Symptomatic treatment, as it is called in the text-books of therapeutics, may give temporary relief when the basic condition which is responsible for the symptoms is obscure or unkown but the obligation to get at the root of the difficulty remains. So it is with administrative diagnosis and treatment. I prefer the hospital executive who shuns superficiality in his search for an elusive cause.

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Question: where is the dividing line between a courtesy and a bribe in the purchasing department, the administrative office, or at the bedside? I wish that I could be sure of the answer but the least that I can do is to advise you to play safe when you're in doubt.

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Style — as expressed, for example in clothing and the like — being very much a luxury, has no place in the hospital. The nurse's uniform is a good illustration of what I mean and I am sure that you can think of many other examples.

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Cleaning is one thing and *polishing* is another. The former is an absolute necessity and the latter (if only because there are substitute materials available) reflects luxury.

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The telephone is an indispensable instrument in the hospital but you will be wise not to entrust an important dialogue to the telephone, and arrange to meet your "party" face to face.

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You are inviting trouble if you stand idly by while a subordinate of yours (see your organization chart) transacts hospital business with your board, or any member thereof — unless he is under specific orders in doing so!

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"Let your conscience be your guide," but only if it is a strong one — as it should be in any servant of the sick.

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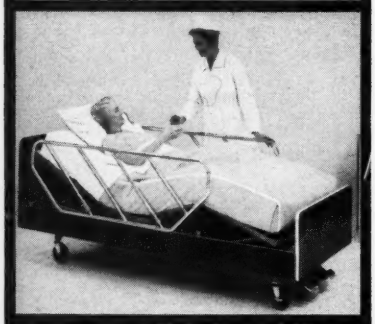

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